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COMMON EMOTIONAL PROBLEMS OF CHILDREN: THEIR OCCURRENCE AND PREVENTION*

ROBERT C. BROWNLEE, JR., M. D.
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The author sets forth here some of the common problems seen in the routine care of children. These include among others the jittery, colicky baby, feeding problems, temper tantrums, problems resulting from permissiveness, school phobias, enuresis and thumb sucking. Some pertinent points relative to the cause of these problems are outlined and an approach to the prevention of them is set forth. Emphasis on the importance of the general practitioner and pediatrician in their everyday contacts with the children and their parents is stressed.

In the everyday routine of office practice, whether one is a general practitioner or pediatrician, he sees many children with emotional problems; some of these problems are to be discussed below. These problems are not of major psychiatric significance in themselves, though they may lead to severe problems. However, they are real problems to the parents and, therefore, problems to the children. In dealing with children, their parents, and their problems, it is important to be able to differentiate between the relatively minor and the relatively major problems, so that we are able to know the ones with which we can be of some help and the more major ones which are beyond the scope of most of us and perhaps need referral to the psychiatrists. The majority of the problems presented in children, particularly in the younger children, are not of a major nature that require psychiatric help; yet some of them are, and in these few, with our inexpert probing, we may do more harm than good and, therefore, they should be referred for more expert help. However, the pediatrician and general practitioner can be of considerable help in the majority of the behavior and emotional disorders of the child and it is with this in mind that we present this discussion.

It is important also that we all realize and understand that some parents have such severe and deep-seated emotional problems of their own that we may not be able to modify their approach to the child. But the majority of parents, with minor emotional problems common to all of us, can be spared many of the pitfalls of child-rearing if they are given proper guidance and instruction as they go along. Some people apparently feel that such guidance is impractical and too time-consuming, but I would disagree. As a matter of fact, a physician may save himself more time than he spends if he can help to prevent the problem rather than trying to solve it after it occurs. In addition, the saving in parental anxiety and the resultant diminution in the child's problem is more than worthwhile. It is a rather hopeless task to solve the problems of adults and our only hope for bettering humanity seems to be in trying to cut down as much as possible on the problems of the children of today as they go through the very

*The material in this paper was presented as a lecture at the University of Oklahoma Postgraduate Seminar.

important formative years from the emotional standpoint — that is, the first five years of life. The remarks that we have to make about these various problems of necessity will be brief and sometimes too general and sometimes too arbitrary. The principles involved, I hope, will be of some help and importance to you.

For the sake of organization, the various emotional and behavior problems and the danger areas related to them will be discussed by age as they arise rather than by frequency of occurrence or severity.

The "Nervous" Baby. — One does not ordinarily think of emotional problems existing in the first few weeks of life, but they do occur and more often in the first born child. We have all seen the scared, insecure, under-confident, tense mother who isn't really sure that she wanted a baby and who can't understand exactly why she doesn't feel a gush of mother love the first time she sees this not-too-pretty new baby that is brought in to her. Of course, frequently there is some degree of rejection of a deformed child, but I am speaking primarily at this point of the normal newborn baby. In this situation we encounter the "jittery", colicky, crying, irritable, so-called "nervous" baby. He fails to respond to sedatives, colic preparations or anything else until his parents and, therefore, his environment become much more peaceful and secure. Thus we have the first emotional problem of childhood. Fortunately, most parents and children get over this situation, but others don't and this general situation may persist throughout childhood. Some of these children later turn up as very over-active children who over-respond to everything because this is the only response they have learned from their parents and they seem to feel that it is also expected of them. Most of us have been confronted with the child who pulls the stethoscope out of your ears, tears up the paper on the examining table and makes a complete shambles of the room, the mother and you. This is what we mean by the over-active child.

The essence of prevention of this baby's reaction lies in the education of the parents and should start, if possible, during the mother's prenatal care. The general practitioner has a unique position and opportunity to do this. One should try to instill confidence in the mother in her ability to do the job at hand, help her to avoid getting a pre-set idea of what she wants her child to be or to be like, propagandize her to accept things as they come, warn her that she might not immediately feel attached to the baby, remind her that it will take a while to adjust herself to the baby and the baby to her. All too often, prenatal care consists solely of caring for the mother's needs as an obstetrical patient without regard or attention to preparing her for her role as a mother. This is perhaps akin to handing a young teen-ager a new high-powered, well-tuned car ready to go, without first giving him driving lessons.

We will move on rapidly to the newborn period: While the mother is in the hospital, some time spent in instruction in the care and handling of her new baby is essential. She should be told as much as possible what to expect in all phases of the baby's reactions. She should not be handed a formula or told to nurse the baby and change the diapers. The details here are too numerous to go into, but let us say that detailed instructions to the new mother are absolutely necessary. Give her plenty of support and reassurance. Let us all remember that parents are not born experts, but are made. While we do not mention the matter to the parents, we know that the seeds of "deprivation of affection" may be sown in this initial rejection of the baby, if the mother becomes too upset by the endless details of its care.

Early Food Rejection. — A less common problem associated with eating probably comes next in the sequence, and we see this in the four to eight month old child and sometimes even earlier when prematurely advanced feeding schedules are instituted. This is the child who refuses all or most of the solid foods and fusses or screams every time his mother approaches him with a feeding other than breast or bottle. This usually results from an improper approach or attitude on the mother's part. She is afraid of feeding her baby and if he gags or chokes she goes off in a tail-spin and, of course, upsets the baby. This makes the feeding time unpleasant and therefore the

baby associates unpleasantness with foods and tries his best to get away from the unpleasant situation by screaming and refusing to eat.

The mother must realize that children vary as to the time they are ready to accept solid foods. The recent trend to earlier and earlier addition of solid food to the infant's diet in many cases only adds to this problem. We are forgetting at times that the normal infant up to about three months has a reflex to stick out the tongue to expel from the mouth anything put on the end of the tongue. This is not to say that many infants won't eat the food, but the mother must be aware of this characteristic. Here, again, calmness and confidence on the mother's part are essential. She must transmit her feeling to the baby that she is capable of doing what she is about to do and he will accept it much better.

Sleep Resistance. — Sleep resistance may begin somewhere around four or five months of age, but more commonly is seen at seven to ten months of age. We have all been confronted with the mother and father who say the child won't sleep and they are all worn out. The problem presents itself as a child who refuses to go to sleep and cries mightily when he is put down. Therefore, he is taken up again and the effort is made over and over again. Or, it may appear in the form of the child who goes to sleep only to waken repeatedly during the night. Each time he is taken up and an attempt is made to soothe him. He is put back to scream, gets up again, goes down again, ad infinitum. This sleep resistance problem may happen to very sensible parents as well as to those with less insight and it usually starts very innocently. The baby begins to teethe, develops a respiratory infection and is awakened with a stopped up nose or earache or goes to visit away from home and gets his sleep habits out of order. Any of these everyday things may set off a sleep resistance problem. When he cries with this the parents rightfully try to calm and comfort him. The babies find this is most pleasant and being the self-centered individuals that they are, they decide to come back for more and more of the pleasantry. However, since they have an insatiable appetite for this sort of torture to their parents, they find themselves hooked and the process is repeated purely out of habit. Then the less the child sleeps, the less he wants to sleep, the more irritable and tired he becomes. He frequently also becomes fussy in the daytime. The mother becomes upset and may come to find herself wishing that the child would just go away. Of course, it is obvious that this may lead to all kinds of general emotional disturbances as the balance of affection between mother and child is upset. This problem of sleep resistance may appear in children several months or even two or three years older than the seven to ten month group. When it occurs in the two and a half to three year old child it is a problem of major proportions and it is more than likely insoluble by routine methods.

About ten years ago Spock described this problem so well. This description and his treatment have stood up well. This situation happens so often to parents who are too permissive or to those who are caught temporarily in the trap of permissiveness when the child is sick. In the latter group this can easily be prevented by a word of caution to the mother of the seven or eight month old child whom you see with an otitis, whose mother says that she has been up off and on the past night or two with a crying baby. Tell her to expect this, but that in another night or two he will no longer be in pain and after this she should put him down and let him cry it out. It is as simple as that. With the too-permissive parent, however, much more detailed instruction is necessary. One needs to set reasonable time limits on bed time to begin to form these habits in the child, to let him know what is expected of him and to let the mother gain confidence in herself and in her ability to handle the child. She must be made to realize that the child not only gets into trouble without reasonable control, but that he is miserable without it. This is often a most valuable object lesson to timid parents.

Problems From Permissiveness. — The months around one year of age are fairly clear of problems except those that arise from the situation of overly-permissive parents. These problems come throughout the life of the child, but this is as good a time as any to refer to them. These children have known very

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few, if any, limits or boundaries. They do not know what is expected of them. Because of their inborn nature, which is essentially that of a completely selfcentered, uncivilized savage, their desires cannot be satisfied. They then develop into dictators and one only has to remember recent history to know that it is impossible to satisfy a dictator or to compromise with one. This child is in the same position. He becomes unhappy. He doesn't know what he wants and when he gets what he thought he wanted, he immediately doesn't want it. These symptoms are made worse by the normally short attention span present in this age group. Recently I had occasion to see an analysis of some 13,000 case histories of alcoholics and the conclusion was drawn that a significant percentage of alcoholics developed from children who had had overly-permissive parents. If the torture of living with one of these individuals as children isn't bad enough, certainly this later specter of alcoholism should be enough to make some parents see the light, if it is possible for them to do so.

In discussing prevention of sleep resistance, I mentioned some of the problems associated with permissiveness. Other points pertinent to prevention can be made. It is necessary to point out to some parents that truly mature parent love for a child does not necessarily mean that one should be permissive with the child and let him rule himself and his family. This is more a flight from the true responsibility of parenthood rather than a manifestation of love. We try to prevent this very early in the course of our discussion with parents as they come in for well-baby care. In those parents where it is obvious that these tendencies exist or are developing, let us point out to them the necessity for early changes in their attitudes. Let us not be afraid to recommend positive action, but perhaps point out to the parents that while we can recommend this to them, it is their responsibility and opportunity to carry out these things and to enlarge upon these and other examples of disciplinary measures discussed in well-baby conferences.

Eating Problems. — Next in the sequence— around the 15 to 18 month old period — we will list an eating problem under emotional problems. Actually, the usual drop in appetite or so-called physiologic anorexia is entirely normal here, but so frequently it is made a problem by parents who do not understand this. Then they attempt to force, nag, bribe or beg the child to eat. They try all kinds of tricks of entertainment — all to no avail. If the parent becomes obnoxious enough she makes the eating experience an unpleasant one and again the child associates food with unpleasantness and a problem is created that may last for years or even a lifetime. Unresolved, this may manifest itself later in one of two ways: Either the child maintains his rebellious approach — therefore he continues to dislike food and won't eat — or he knuckles under and, in an attempt to gain acceptance by this parent who is obsessed with the idea that the child must eat, he eats himself into obesity. Either situation is bad and propagates further difficulty.

These eating problems are very common and in most cases can be prevented. In attempting to prevent them, ordinarily we start at about the nine-to-ten-month old visit telling the parents about the expected drop in appetite which will occur later. We show the rapid and large weight gain of from 13 to 16 pounds (300% increase) which usually occurs in the first year and point out how tremendous the intake of food is here for size. Next, predict the expected weight gain of 4 to 5 pounds (25% increase) for the second and subsequent years and predict the appetite drop. As we give a reasonable explanation for these things, most parents are able to accept this, because it is so sensible. With later visits at 12 to 15 months, this same ground is gone over again and usually it sinks in. Now we begin to describe the usual diet of the 2 year old — that is, mostly meats and few vegetables — explaining that he shouldn't have a quart of milk a day, but rather about a half pint to a pint. Ask the mother who weighs five times as much as her child if she thinks she can drink five quarts of milk a day when her child drinks one. Perhaps this is taking unfair advantage of her, but it makes the point stick. These are not fancy psychological schemes, but just the facts as they stand and if properly presented the majority of mothers will accept them and we will have prevented an eating problem.

Temper Tantrums. — Temper tantrums occur to a varying degree in almost all children sometime between one and three years of age. Their persistence or marked frequency is the only situation in which we consider them a problem. This may occur from too few parental demands (permissiveness) or too many parental demands from the overly-strict parent.

As indicated above, in attempting to prevent problem tantrums we must harp on permissiveness again, for this breeds temper tantrums, so our efforts to prevent permissiveness by the parent pays off again. On the other hand, the too-strict approach also stimulates tantrums. Both these points must be made to parents. We need to tell all parents to expect tantrums, that they are normal, and therefore they must not be upset when they occur in their children. The mother must be warned that she cannot punish the child out of them or give in to his demands to try to stop them. Both approaches only cause more tantrums and thereby make a problem out of a normal thing. An appropriate attitude for the parent would most closely resemble boredom with the child's antics. This instruction in the handling of the occasional tantrum usually prevents the recurrent problem tantrums.

Toilet Training. — Also, at this age or hereabouts, we begin to encounter the problems associated with parents' efforts to get the child out of diapers and on to the toilet. Unfortunately, parents of a generation or two ago were taught that early toilet training was indicated and now those parents are grandparents and lots of education of the parents of this generation is necessary to counteract one or two words handed down over the years. Many parents do not realize that the mastery of urination and defecation is a matter of development rather than training. Those that do realize this often strive to get their child "trained" early in an effort to show that he is smarter than the child next door. Children of this age have usually developed some degree of negativism anyway and efforts to get them to do almost anything, much less to use the toilet, are met with resistance. All too often Mama tells the child "to come on now and have a BM for Mommy". The truth of the matter is that nothing could suit him less. Children seem to be rather proud of their stools. It is something they have produced for themselves and are not a bit interested in producing for Mama or anybody else. Often this results in the child's holding back and really making a problem. The resulting battle between mother and child can be rather fierce and prolonged. Since, as the psychiatrists sometimes say, this is an emotionally-loaded area, long-term and far-reaching emotional problems in later childhood and adult life may be the result.

Here again, the circumstances surrounding toilet training can be kept from becoming a problem only by an early start in educating the mother about its proper handling. This discussion should be started even as early as six months with some mothers, since they may have been told by someone to start putting the child on the toilet as soon as he can sit alone. Certainly as early as one year, we should tell the parents that the use of the toilet is an accomplishment attained usually around two years. Tell them that it is a matter of development and not of training. It seems unfortunate that the term "toilet training" has come into our vocabulary, for this indicates to the mother that this so-called training is her doing rather than the child's. If we can get it across to the mother that she should think of this in the same light that she thinks of walking — that is, that the child will do it when he is developmentally able — then she will be less likely to exert undue pressures on the child and she will have prevented a problem from developing from a normal physiological process.

Negativism. — We have mentioned negativism previously and this reaches its height around the age of two. This is not a true emotional or behavior problem, but rather it is a normal developmental phenomenon. This presents a problem only if the parents are not prepared for it or do not understand it.

Perhaps this sounds like a broken record, but we must prepare the mother for the appearance of negativism so that it does not become a problem to her and affect her feelings toward the child. Efforts should be made to help her to accept it for what it is — his uncertain attempts at trying to achieve some degree of independence. Help the mother not to

be too permissive or too strict in her handling of the child at this time — a large order!

Sibling Rivalry. — Perhaps this would be a good time to discuss the matter of jealousy and sibling rivalry, since frequently by this time the first child is around age two to three and a new child is coming along. Jealousy is frequently manifested by the child doing almost anything to obtain attention, since he feels pushed aside by the new arrival. At any rate, this seems to him a threat to his secure place in the family. It is common for him to do such things as emptying the garbage can in the middle of the floor, turning on the washing machine or making a bolt for the door, sans coat, when it's snowing outside — just as his mother gets settled to feed baby brother. These are but a few manifestations of his play for attention and the variations on this are as many as there are children with new babies in the household. When a mother says a child is "driving her crazy", try to find out why. Usually this is over-activity to attract attention.

This jealousy is a normal thing and parents must be told to expect this. Its occurrence cannot be prevented except by not having any more children, but this is too big a price to pay so we need to direct our efforts at modifying it. We try to help the parents to understand that this is a normal feeling. Then they realize the necessity for giving the first child positive attention rather than shunting him aside while everyone glows over the new arrival. The older child must be made to feel that this new baby has not and will not displace him from his secure position with his parents.

Dawdling. — Dawdling is a frequent complaint in the preschool and school age child. Part of this is normal. When it becomes excessive then it becomes a problem. Frequently this is an evidence of passive resistance on the child's part to nagging or excessively demanding parents. The child may not choose to rebel openly, but does so in this passive manner. An effort should be made here to get the parents to relax their controls and allow a little more independence.

Lack of Independence. — As the child gets older and more a citizen of a larger group than the family circle, we run into other problems. Parents come in complaining that their children won't play with other children or won't go next door without the mother or won't stay in Sunday School or he refuses to play well with visitors, etc. These things we see most often in children who have been overprotected and thereby not allowed to develop even normal independence for their age. In the slightly older kindergarten and early school age child this is also a problem, and for the same reason usually.

School Problems and School Phobia. — Now as we get to the school child the problems become more complex and oftentimes their causes are harder to pin down. Here we encounter the problems of adjustment to school or perhaps we should say adjustment to leaving home. Also, we commonly have to investigate the problem of the child who is doing poorly in school. Of course, this may be on the basis of inadequate mental capacity, but we are concerned here about those with adequate intelligence who, in spite of this, do poorly. These usually represent the immature children alluded to above or children emotionally disturbed for other reasons. So often this may be brought on by the fact that parents are prone to want to "push" their children. Too often parents are misled by the fact that the child may be of relatively high intelligence without this necessarily meaning that his emotional maturity has kept pace.

One further problem which should be discussed in the school age child is so-called school phobia. Many children have varied tension complaints about going to school such as anorexia at breakfast, abdominal pain, various aches, hay fever symptoms, etc. — all of which disappear after getting to school. These may be compared to stage fright which occurs even in an experienced actor. However, we are referring to the problem which has been defined as "an inability to go to school that results from an irrational dread of some aspect of the school situation". In brief, this stems from the fear of separation from the parents or so-called "separation anxiety". It is commonly seen in children of parents who actually promote this sort of thing by their pathologic need for the child to remain with them. It

frequently occurs in the mother with over-protective, over-permissive attitudes.

These school problems mentioned above may frequently result from a disturbed and deprived relationship between mother and child, especially in feeding and toilet training situations. This then points up the importance and necessity for preventing these earlier problems, and they can be prevented. As mentioned above, over-permissive attitudes on the part of parents lead to this sort of problem. Too often the parent is over-permissive in an effort to compensate for guilt feelings or hostile feelings of lack of acceptance of the child. We have pointed this out from the onset, so we have come a full circle already in that we are seeing secondary problems from a primary problem that perhaps could have been prevented or at least modified.

Thumb Sucking. — We have purposely left two other problems until the end, since they do not particularly present themselves as problems according to age. The first of these is thumb sucking. There is much heated discussion, many misconceptions and very little rational approach on the part of most people to this situation. First, let us state that this is really not a problem to the child unless it is made so by the parents' attitude toward it. It is a normal habit which occurs in approximately 55% of infants. In the vast majority of patients, no dark, sinister meaning of insecurity or lack of affection should be attached to it. Of course, there are a few children in which some emotional upset may be associated, but these are unusual, and almost always there are other symptoms of more significance.

Thumb sucking is usually worrisome to mothers and yet such a pleasant pastime to children. In an effort to prevent this from becoming a problem to the parent and child, we should begin by educating the mother to accept this as a normal habit from the moment we know that the child is thumb-sucking. Most mothers will accept an infant who does extracurricular sucking and yet she will get upset with an older child about it. If we can assure her that this is a normal habit, that it does not indicate insecurity, that it will not necessarily result in teeth abnormalities, etc., then we can preserve the normal mother-child relationship and thereby prevent this from becoming a problem. When a mother says, "my child is thumb sucking and what should I do about it", we try to tell her to do nothing about the child but to work on her own feelings about it. This approach does work, though it may take a good bit of brain-washing.

Enuresis. — The second problem is that of enuresis. Let us define enuresis. This is a persistence of night wetting or day time clothes wetting beyond the age of five years. Night wetting before this age in many children is a perfectly normal thing. Others may be dry as early as one year, but this doesn't mean they all should. It is important to make this age distinction because if the parent is aware of this, then we may prevent prolonged enuresis by eliminating the early apprehensions, for this in turn results in pressure on the child. The etiology of true emotional enuresis in the older child varies and the following causes may be listed: severity of toilet training, regression under psychological stress, fantasied mutilation after surgery or injury, identification with an incontinent parent, etc. Severe emotional upsets such as these present problems which are probably best handled by the psychiatrist. The many regimens of treatment and gadgets available may rarely be of help and usually may cause only further conflict in the parent-child relationship.

In our efforts at prevention of enuresis or of this becoming a problem to the parents and child, we must refer again to the definition which indicates the persistence of unusual wetting beyond age five years. If this one point can be gotten across to the mother of the child at age two, three and four, then by this simple means alone we may prevent the problem, because in so doing we have been able to keep the parents from putting pressure on the child, to keep them from punishing him or shaming him, etc. Some cases, of course, may have more deep-seated causes. One of which, as previously mentioned, was severity of toilet training. Here again we are coming to secondary problems that might not have arisen had we

prevented the problem associated with toilet training in the first place.

You will notice that we have emphasized almost entirely the emotional problems of the younger child. This has been done out of necessity because we started out by stating that we were discussing the majority of the problems that we see or the so-called minor emotional problems of children. As a child grows older, the problems are almost always more serious, and may assume major proportions. Besides, it is our distinct feeling that we have a chance of modifying problems only in the first few years of life and that if we have not been able to modify the parents' approach to their children by the time the child is five or six, then the situation becomes relatively hopeless in the hands of the average practitioner.

These, then, have not been, by any means, a complete list of minor childhood problems, but problems that can be prevented in many children with the proper guidance to parents. You may have noticed that we have not indicated any unusual or dramatic preventive measures, but mainly have tried to get across an attitude or approach. This approach is mainly concerned with the education of the parents, sometimes a truly difficult job, but yet it can be accomplished to a very satisfactory degree. This works, but it takes time. Yet you may save time, for it is much easier to prevent these problems than it is to solve them. Perhaps our only role as pediatricians and general practitioners in emotional problems is that of prevention, and perhaps we might well leave the role of treatment to the psychiatrists.

THE DEATH OF STONEWALL JACKSON

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May 2, 1863 was the date! Chancellorsville! One of the greatest battles of strategy ever fought had begun that morning. General Jackson with 28,000 men had marched to the left, leaving Robert E. Lee with 15,000 facing 60,000 Federal troops. To get to Hooker's right flank Jackson was taking a roundabout way in order to take him by surprise. Jackson's men marched all morning. At 1:00 p. m. they rested, as Fitzhugh Lee had found the enemy and his dispositions. By means of the Brock road from the Catharine Furnace, Jackson kept north until he was well beyond the right flank of Hooker's division at Melzi Chancellor's. Between 1:00 p. m. and 4:00 p. m. the brigades of Lane, Pender, Heth, Rodes, A. P. Hill, Colston, Ramseur, and Paxton—all commanders under Jackson—had been brought into position against the right flank of the Federals which "hung in the air". At 4:00 p. m. they deployed in the woods. At 5:15 p. m. the battle was joined and Jackson savagely hit the lines of the Federal troops stretching from Chancellor's northwestward to the fords of the Rappahannock. The roar of battle proceeded, shell and shot screaming with the noise and yells of the troops charging forward.

By 7:30 darkness had fallen, the Confederates had broken the Federal lines and proceeded beyond Melzi Chancellor's toward Chancellorsville two miles away, where rested the main headquarters of the Federal armies, whose main lines had been kept busy by Lee's feints during the day. The charge was so tremendous, the pursuit so hot, that the Confederates had difficulty in keeping their lines. As the moon rose there was much confusion and a tendency for the right of the Confederate line to fall back. Jackson's order was still "Press onward, press onward", but because of the confusion and the slowing up of the right between 7:30 and 9:00 p. m., he and his staff rode forward to see if by continued attack the Confederate troops could double back the right wing of the Federal army to cut off their retreat.

About 9:00 p. m., Jackson with his staff had

come up to the front lines. He told his troops that the enemy had been routed and urged them to press on. Having later gone even further forward through his own picket lines, Jackson's staff became solicitous for his safety and urged him to go back, so he turned his horse and proceeded to his own lines. While riding along silently opposite a weatherbeaten house known as Van Wert's, suddenly from the south of the dark road came a shot, and a volley roared through the woods.

"Cease firing, cease firing," General Hill's voice rang out, but the nervous soldiers in the front line, believing the order to be from the Federals, poured out another volley. Jackson, whose horse had suddenly swerved and dashed away toward the north into the woods, suddenly ran into a long flash of fire, a volley by a kneeling line. Instantly he had been hit. His left arm fell limp; he lost his grip on the bridle, and a bullet struck his uplifted right hand. At almost the same moment he had a sudden blow from a bough that almost unhorsed him.

Desperately, and in spite of his wounded hand, Jackson began to pull in the frightened horse. Then as he felt himself grow dizzy, another officer dashed up. When asked how he felt, the General replied weakly that he could not move his fingers on the right hand and that the left arm was broken. When Wilbourn attempted to reach up and straighten the arm the pain was so torturing that Jackson had to say "You'd better take me down." As he fell toward Wilbourn he almost fainted.

Quickly a number of officers gathered around Jackson inquiring about the pain. They were assured that he was quite painful, especially the broken arm. His blood filled gauntlets were removed to lessen the pain in his arms and his sword and belt were removed. A drink of whiskey revived him slightly. Lt. James Power Smith tied a handkerchief about the wound as a tourniquet and tried to make a sling for the broken arm. It was noted at this time that the blood had begun to clot.

A few minutes later the assistant surgeon of the brigade arrived and examined the General but decided not to apply a new tourniquet. The next move was to start Jackson back toward the base hospital, but worry was considerable concerning the possibility of starting the flow of blood again. However, this seemed a smaller risk than being captured or hit with other projectiles.

Stumbling even with help, Jackson tried to walk back, but soon was so faint and so exhausted that litter bearers were finally prevailed upon to put him on a litter. As the litter was conveyed backwards heavy cannonading and Minie balls shot down one of the bearers so that Jackson was almost thrown to the ground.

Alternately stumbling with the litter and resting between volleys the General was brought to an ambulance which was found in the woods. Soon the ambulance, in which Jackson was placed along side of severely wounded General Crutchfield, reached Melzi Chancellor's. After much pain and faintness had caused the General to ask a number of times for "spirits" he found here his medical director and friend, Dr. Hunter McGuire, for whom Jackson had not merely respect as a professional man but affection as an individual.

This was history; next comes the clinical story.

Preliminary examination of General Jackson by Dr. McGuire at the forward aid station at Melzi Chancellor's house disclosed that the handkerchief applied as a tourniquet had slipped. This was readjusted and reset. The patient was suffering intensely. His hands were cold. The skin was clammy, the face pale and the lips compressed and bloodless. No groans escaped him. Not a sign of suffering was revealed except the slight corrugation of his brow. The face was rigid, fixed, and the thin lips tightly compressed so that the impression of his teeth could be seen through them.

As soon as bleeding was staunched, Jackson received whiskey and a dose of morphia. These had prompt effect and in a few minutes he was less sensitive to pain. Since he seemed much relieved the ambulance was started to the field hospital, nearly four miles to the rear.

Throughout the ambulance trip to the base hospital Dr. McGuire kept finger pressure on the severed artery so that if the handkerchief tourniquet should slip again there would be no

further bleeding. During the trip the patient conversed with his surgeon and was determined that the confusion of the night should not be increased by demoralization which often follows the report that a leader has fallen. Every time Jackson heard the question, "Who is wounded?" he would prompt McGuire to say, "A Confederate officer".

Shortly after 11 o'clock the ambulance reached the old tavern where the Second Corps hospital had been established on the fringe of the wilderness. A warmed tent had already been prepared by Dr. Harvey Black, surgeon in charge. On arrival the General received more whiskey, was placed on a cot and given abundant blankets. He seemed to come back to life; the pulse became stronger; his body became warm. At midnight his condition was about the same.

At 1:00 a. m., May 3, 1863, Dr. McGuire waited for a stronger pulse and a clearer mind. At 2:00 a. m., Dr. McGuire with Dr. Black, Surgeon Walls and Dr. R. T. Coleman, chief surgeon of Jackson's old division, stood around the General in consultation. Dr. McGuire informed him that chloroform would be administered to make a painless examination of the wounds. When informed that examination might reveal a condition requiring amputation, General Jackson spoke weakly but firmly, "Yes, Dr. McGuire, do for me whatever you think best."

Preparations began. Dr. Coleman quietly rubbed over Jackson's face a protective salve and the surgeon then folded the cloth into the shape of a cup. He placed two drams of chloroform into this cup and placed it over the patient's face. After a few deep breaths, Jackson began to feel its effects. The words "blessing," "blessing" came often, but slowly and jumbled as he relaxed and became insensible.

Examination of the wound on the right hand was made by Dr. McGuire. A round ball had entered the palm, breaking two bones and lodging under the skin at the back of the hand. The bullet was removed and was found to have been fired from a smooth bore Springfield musket, a weapon much used by Confederate troops at the time, but already discarded by the Federals.

Examination of the left arm disclosed an ugly wound. A ball had entered three inches below the joint of the shoulder, had divided the main artery, shattered the bone and passed out. In the forearm a third bullet had struck about an inch below the uplifted elbow, with a wound of exit on the inside of the arm just above the wrist.

McGuire and the rest of the men shook their heads. Conditions were as they had feared. This member was not to be saved, so badly damaged was it with lacerations and loose bone fragments. To prevent gangrene and useless anguish, amputation had to be performed at once.

While Dr. Coleman continued to administer the chloroform and Dr. Black watched the heart action, Dr. McGuire swiftly made a circular incision and sawed off the bone while Dr. Wall ligated the arteries. With so many experienced hands, little blood was lost. After dressings were applied and the anesthetic withdrawn, the salve was wiped off to permit treatment of the wounds of the face. All these were found to be superficial, caused by tree limbs. They were treated with isinglass plasters. For 30 minutes after cessation of the anesthetic the patient remained on the borderline of consciousness, then received a cup of coffee which he was able to retain.

One hour later Major Pendleton broke into the hospital with the news that A. P. Hill had been wounded and Jeb Stuart had accepted the command of the corps. When Jackson was asked for his advice, he was so weak and feeble that he finally could merely whisper: "I don't know. General Stuart must do what he thinks best." The patient's condition at this time was considered satisfactory as to heart action.

On May 3, 1863 at 9:00 a. m. the patient awoke, took some nourishment and displayed a cheering resilience. Prognosis appeared favorable. None of the doctors in attendance seemed to have any fear for his recovery and the patient dictated a note to General Lee informing him of his success. At 10:00 a. m. General Jackson felt so much pain in his right side that Dr. McGuire made an examination. After careful examination of the patient's chest, abdomen and back, no bruise was discovered,

no broken ribs were indicated, breathing seemed to be normal. Local applications were ordered and Dr. McGuire felt no special concern. The patient continued to suffer the rest of the morning, but seemed strong enough to converse briefly with his chaplain.

At 2:00 p. m., May 3, 1863, the patient was relaxed and quiet until disturbed by messengers from General Lee. General Lee commanded Dr. McGuire to turn over all other duties to the senior surgeon and himself attend the General and to remove Jackson to a place less exposed. Whether the journey to remove the patient was to be made the next day was to be determined by Jackson's condition which hourly seemed better. By nightfall he was rid of the pain in his side.

On May 4, 1863, General Jackson having slept well, it was the opinion and judgment of his surgeons that he could now look forward to a normal convalescence. An all day journey removing the patient by ambulance was soon under way. Throughout the journey General Jackson was active in conversation with all with whom he came in contact. There was no confusion of mind and no fatigue. He had no symptoms of distress until later in the day he became slightly nauseated.

Jackson had previously used the "water cure" of Farmer Vincenz Priessnitz and he now asked that wet towels be applied to the abdomen for this distress. This was done with Dr. McGuire's consent. The result whether psychological or physiological was entirely to the patient's satisfaction.

This long journey of 27 miles came to its end at 8:00 p. m. The place of hospitalization chosen had been Chandler's at Guiney's Station. When the ambulance arrived there, the place was full of refugees and sick and wounded soldiers. Because there had been erysipelas in the main house, Dr. McGuire decided that the General was to be given the disposal of the office in the yard, a building which had two or three rooms and could be made into a small hospital. In this abode he was immediately comfortable and relaxed, ate some bread, drank a cup of tea and then fell into a normal sleep.

May 5, 1863: Jackson awoke in good condition, though he felt he had rested less during the night than actually he had. Dr. McGuire early on May 5 examined the wounds. The one on the right hand was giving little pain, but McGuire thought the hand should be splinted to keep fragments of bone at rest. This was done. No serious infection was discovered. The stump of the left arm was doing equally well. Parts of it were healing by first intention. Granulations were observed. The patient ate with heartiness and began to speculate on the length of time that he would be absent from duty. He was quite cheerful. At 10:00 a. m. Tuesday morning, May 5, General Jackson welcomed his chaplain who arrived to conduct bedside worship and to give the General the satisfaction of discussing religion.

The patient spent Wednesday, May 6, 1863, with no symptoms of other involvement and went into some lengthy discourse on theology and church history with his chaplain, A. C. Smith. After this long period of talk, however, his attention began to lag and it was obvious that he was becoming exhausted. Despite this weariness the day seemed to be one of consistent gain and encouragement. At 10:00 p. m., May 6, the patient went to sleep easily.

On Thursday, May 7, 1863, at 1:00 a. m. the General was awakened by nausea. As quietly as he could he aroused Jim, his servant, and told the negro to get a wet towel and apply it to his stomach. Jim was vaguely conscious that this was the wrong thing to do, but Jackson refused to allow him to awake Dr. McGuire. Obediently Jim applied a wet towel to the General's stomach. The cold and dampness did no good. Sharp pains in the right side were added to the nausea. Moment by moment pain increased until it was almost unendurable. The General's frame was shaking with a chill but his resolution was firm. He would not wake his sleeping surgeon. Soon Jackson's pain was sharpened every time he drew breath. Agonizing though the pain was in the chest with each breath, the patient held out until the gray of dawn, then permitted Jim to awaken surgeon McGuire. Dr. McGuire listened to the chest, examined the painful areas and all too readily was convinced of what the patient himself suspected—pneumonia.

After the examination Jackson was not afraid. He did not believe pneumonia would kill him. Confidence, faith and ambition convinced him that he had more work to do. So to the attack on the disease that was assailing him! Preliminary to cupping, which would bring more blood to the affected side, Jackson was given morphia. The patient, of course, was then less sensitive to pain, but the drug threw him quickly into a stupor. From that hour the personality of General Jackson as his officers knew it, seemed to be in a haze; obscured and uncertain. His conversation became a muttering and though he used connected sentences, it was difficult to tell at times whether he was rational or merely babbling.

About noon of May 7, 1863, when the doctors had done what they could, the patient asked for nourishment, and after having received lemonade, he stirred himself to greet his wife who had then arrived at his bedside, but so deeply was he under an opiate that he dropped off to sleep quickly. Later in the day he gained consciousness enough to recognize his wife and give her words of encouragement and love.

At 2:00 p. m. Dr. Samuel B. Morrison arrived, examined the patient, who recognized him. Drs. Morrison and McGuire held a consultation, and as a result decided to call from Richmond the most distinguished authority on pneumonia, Dr. David Tucker. All the while the patient seemed half asleep, half delirious. He was able to rouse himself when called, but if left alone his mind would turn to the battle field. Despite this delirium the doctors did not feel discouraged, though by evening they could not dispute the seriousness of the malady, but believed he was holding his own.

On Friday, May 8, 1863, Surgeons Breckenridge and Smith of the Army Medical Corps had come at McGuire's request for consultation. These three and Dr. Morrison made as thorough an examination of Jackson's condition as was possible. The wounds appeared to be doing well, the discharge had diminished and healing was continuing. Pain in the side was no longer troubling the patient. Some of the surgeons were not sure his prognosis was good. The ominous conditions at this examination were his difficult breathing and his great exhaustion. Of his weakness Jackson himself spoke. Blisters were applied. Later in the day Dr. Morrison expressed a fear that the disease might not be overcome. To this Jackson listened without emotion, but said "I do not believe that I shall die at this time". Even after Dr. McGuire corroborated Dr. Morrison's opinion Jackson insisted that he would recover. Though he had a very restless night he did not appear to be shaken.

Saturday, May 9, 1863, found Jackson's breathing apparently less difficult and the pain diminished, but his weakness was manifestly worse. He still observed intermittently what was going on in his sickroom and that to the intelligent faces of his doctors around the bed another had been added, that of Dr. David Tucker, the Richmond authority on pneumonia. With his increasing weakness there was much fever, but he was still insistent on his probable recovery. When he asked to see his baby he beamed at her in no spirit of farewell.

Late in the afternoon of May 9 he had his doctors summon the chaplain. At the time Jackson's lung was so nearly filled that his breathing was very difficult. Such respiration as he had was shallow and cruelly fast. For these reasons Mrs. Jackson and his physicians tried to dissuade him against conversing with the chaplain. Cough had begun and produced "putrid" sputum. During the evening he listened to psalms and asked for singing of hymns. These seemed to have a quieting effect and he rested in what seemed to be perfect peace. During this evening all the surgeons in attendance felt that the end might not be far distant. During the night he lost ground. He seemed to get no relief except from cold sponging of his face and forehead. As he appeared to be sinking steadily, one of the physicians tried to get him to take a drink of brandy. He tasted it but refused the rest.

On May 10, 1863, Sunday, the patient was in a stupor. He lay in bed breathing hard, saying nothing. At about 11:00 a. m. the doctors informed him that this was his last day to live. Between muttering delirium and stupor he would rouse at times. Weakness was severe and extreme; pulse was rapid, thready and weak. He had much cough and very shallow,

rapid and difficult breathing. His face seemed now emaciated and strangely ascetic. When attempting to play with the baby he sank back into unconsciousness.

During the afternoon he lay almost unconscious, quiet except for stertorous, difficult breathing which was accompanied by some cough and a loud rattle in his throat. At 3:00 p. m., after a long, long silence during which only the breath in his throat could be heard, the patient said from his bed clearly, quietly and cheerfully "Let us cross over the river and rest under the shade of the trees." He then expired.

This is the clinical history of General "Stonewall" Jackson's death. Obviously the wounds with severe lacerations requiring sutures through major vessels, with much tissue damage had produced a pulmonary embolism which so often was diagnosed pneumonia or putrid pneumonia. The rapid onset during the night, the severe symptoms, the protracted weakness, the fever and chills, and the chest pain and cough all signify pneumonia. It does not seem too imaginative to suppose that this pneumonia, beginning with acute pleurisy, was an infarct of the lung due to a pulmonary embolism. As a clinical history it is interesting for this reason. Consider the difference between then and now. Morphine, cupping, blistering, strychnine, brandy and whiskey seemed to be the means with which to combat pneumonia. Contrast this to the present when oxygen and antibiotics have made so much difference.

But so much for the medical history.

Now let us consider metaphysics, briefly.

During Jackson's last hours when he first was told by Dr. Morrison that his disease might not be overcome, Jackson's answer was "I am not afraid to die, I am willing to abide by the will of my Heavenly Father." Later he told his surgeon, McGuire, "I see from the number of physicians that you think my condition is dangerous, but I thank God if it is His will that I am ready to go."

Later when his wife asked if she should read some of the psalms of consolation he shook his head vaguely but no sooner had he spoken than his discipline and will asserted themselves even in a stupor. Would he not heed the Psalms, the word of God? "Yes," he corrected, "we must never refuse them" and then managed to add briefly, "get the Bible and read them."

Later when Mrs. Jackson had to ask the General, "Do you know the doctors say you must very soon be in Heaven?", he answered finally, "I prefer it" and repeated it carefully, "I prefer it." When she replied, "Before this day closes you will be with the blessed Saviour and His glory," he seemed to steady himself for the effort of speech and said deliberately, "I will be an infinite gainer to be translated."

At 11:00 a. m. of the last morning full consciousness seemed to return to him and when his wife told him that he was about to die he said, "Oh, no, you are frightened, my child, death is not so near." It was only when his surgeon replied that medicine had done its utmost that Jackson seemed to ponder and gazed upwards for a few minutes then, as in battle or when some shining deed was performed he would say "Good, good," he now seemed to think the orders of a high command had been given. His response was stronger, "Very good, very good. It is all right." With that answer he turned to the weeping wife and tried to comfort her. When he finally understood a question regarding where he wished to be buried he answered, "Lexington and in my own plot," but he spoke of it casually.

In accordance with the customs of the day, it seemed proper that the dying man say farewell to his child. The baby was therefore brought in by the nurse. He seemed to recognize the child and was much pleased to see her rather than to talk funerary details. Through the fog of morphine and weakness he played with his child and called her endearing names until he sank back into unconsciousness.

When next he was aroused, "Sandie" Pendleton was standing beside his bed and they conversed as to who was preaching at the headquarters for the Army. Jackson was gratified that his own chaplain was there by his forgotten order. He was also pleased that the men were to hear so eminent a preacher and when informed that the whole Army was praying for him he murmured, "Thank God. They are very kind. It is the Lord's day. My wish

is fulfilled. I have always desired to die on Sunday."

About 1:30 of the afternoon, when he was informed that he might not have two hours to live, his answer was 'Very good. It is all right." And then came more of muttering and delirium and concern with the movements of the armies.

Thus died Stonewall Jackson.

How many of our patients today die in similar circumstances of faith, friendship and familiar faces? Consider the firm and abiding faith with which this man, from an almost miraculous escape from death by bullets, could suddenly reverse his hope and ardor for living to a complete peaceful acceptance of the inevitability of death. How many of our patients today, lying in hospital beds, in oxygen tents, with all sorts of sedatives to smooth the nausea and vomiting and pain—how many of them have this extra comfort, such as displayed in this story? Slowly this feeling of reverence for death has withered. All the miraculous medical wonders and material gains have not assured us of an acceptance and an abiding faith. Patients and their families desire and demand by every known, unknown and half-guessed new medical research to prevent death with no clear conviction that every man must die. It is this very lack of a firm acceptance and faith in the inevitability of death, whether it is the Christian faith or whether it is some other type of faith which binds man to the infinity which is the universe, which has lost us one of our cardinal medicines. We have lost it in our seeking for medical miracles of a chemical or botanical origin.

I urge you therefore to examine this example of faith. Encourage faith in your patients. Converse with your patients about death. It is surprising how many patients are dying in hospitals alone, afraid—afraid even at the moment of death—afraid and unsure. The comfort of faith is as necessary as oxygen.

Thus was a case of pulmonary infarction. It was a great case, not because Stonewall Jackson was a great man, but because of its simplicity: the simplicity of the man, the simplicity of his clinical disease, and the simplicity, but yet the greatness, of his dying.

RECURRENCE OF MALIGNANT MELANOMA AFTER 21 YEARS

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A white female, age 33 years, was seen on January 3, 1939, with the complaint of a "skim over the right eye for about a month, gradually becoming blind." She had no previous eye trouble, was in good health, had five children, the youngest of which was seven months of age. The vision in the right eye was light perception; in the left eye, 20/20. There was a dark mass in the nasal half of the fundus of the right eye extending back to the disc and as far forward as could be seen. Transillumination was defective on the nasal portion of the globe. A tentative diagnosis of melanoma of the choroid was made and immediate enucleation was advised. On January 5, 1939, under local anesthetic, the eye was enucleated. The specimen was sent to Dr. T. L. Terry, pathologist at the Massachusetts Eye and Ear Infirmary, who reported "malignant melanoma of the choroid and ciliary body, Spindle B type."

In November, 1959, the patient consulted Drs. Dickson and Clarke of Due West for weakness, lack of energy, and headache. She was seen again by them in August, 1960, at which time they reported "there were multiple, dark subcutaneous nodules scattered over the body, thought to have been melanomata." They referred her to Dr. J. H. Young of Anderson, who reported as follows: "Examination

revealed several nodules scattered over her body, a fairly large one under the mandible, another one on the posterior thoracic wall between the shoulder blades. These nodules were quite firm, were bluish in color, and were subcutaneous . . . . the liver was enlarged down to the iliac crest, and one could palpate nodules in the enlarged liver through a rather thin abdominal wall. It was our impression that this did represent disseminated malignant melanoma and that no treatment was indicated other than symptomatic."

I was informed by a relative of the patient that she expired on December 25, 1960. This case was thought to be noteworthy due to the fact that there was a 21 year interval between the time of the original lesion and of her demise from a similar condition. It is unfortunate that biopsy was not done during the last illness.

TREATMENT OF TUBERCULOSIS*

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An inevitable result of the rapid advances being made in the chemotherapy of tuberculosis has been a change in the basic philosophy of treatment. With the introduction of agents specifically toxic for tubercle bacilli, it is apparent that now there is an opportunity for direct frontal attack upon the organisms which cause this disease. Whereas, formerly, therapeutic measures were strictly defensive, at the very best an indirect attack aimed at causing the disease process to subside by encapsulation, now the emphasis is on eradication of the parasite. Along with these advances has come the necessity for the clinician to understand as much of the fundamental aspects of the drug-parasite-host relationships as possible in order to be able better to care for his patients. As a result of these basic changes, the treatment of tuberculosis has become more complex than that of any other infectious disease.

Attempts to evaluate antimicrobial chemotherapy by means of roentgenographic and other less specific clinical studies have not been so profitable as preoccupation with the microbiologic phenomena in this disease.

The first, or short-term, aim of chemotherapy in tuberculosis is to convert the sputum (or other body exudates) of as many patients as possible to a bacteriologically negative state as soon as possible with a minimum risk of drug toxicity, a minimum cost, and a maximum of patient cooperation. It is not enough, however, in a chronic relapsing disease like tuberculosis to aim merely at the bacteriologically negative state. It is equally important to avoid bacteriological relapse at some later date. The long-term aim of the chemotherapy of tuberculosis, therefore, is the prevention of bacteriological relapse with a minimum drug toxicity, a minimum cost, and a maximum of patient cooperation.

It is self-evident that failure either to attain the short-term goal of conversion of the sputum (or other body exudates) to a bacteriologically negative state, or to prevent subsequent bacteriological relapse constitutes a practical definition of failure of drug treatment. There are, actually, three types of failure. First, there is failure to achieve the bacteriologically negative state coupled with persistence of drug-susceptible organisms. Second, there is failure to achieve the bacteriologically negative state with the appearance of drug-resistant organisms. And, third, there is bacteriological relapse in which tubercle bacilli, whether drug-susceptible or drug-resistant, are once more present in the sputum.

The natural or acquired defense mechanisms of the body, of whatever origin, may

*This presentation is primarily based upon observations made by Sidney H. Dressler, M. D., Chief of Staff, National Jewish Hospital, Denver, Colorado, at a meeting of physicians sponsored by the Section of Tuberculosis Control, South Carolina State Board of Health on Janaury 26, 1961.

contribute to the effects of antimicrobial agents which have chemotherapeutic value in the treatment of tuberculosis. It is obvious that a great variety of tuberculous lesions can exist simultaneously in the lung of the patient with pulmonary tuberculosis. However, the immediate stumbling block in present day chemotherapy is the open cavity.

Tubercle bacilli are strict aerobes. Molecular oxygen is essential for multiplication of *Mycobacterium tuberculosis* in vitro, and also in vivo. This is of primary importance in the chemotherapy of this disease. There is quantitative relationship between the rate of bacterial multiplication and the rate of sterilization by each of the primary drugs, that is: isoniazid, PAS and streptomycin.

The persistent excretion of drug-susceptible tubercle bacilli by some drug-treated patients has been interpreted by many clinicians as evidence that the drugs employed exert a purely bacteriostatic—not a bacteriocidal—effect upon these organisms in man. Russell, Dressler, and Middlebrook have presented evidence that this phenomenon is more reasonably attributable either to inadequate dosage of drug or slow rate of multiplication of tubercle bacilli due primarily to oxygen deficiency.

Below are condensed, specific recommendations relative to the treatment of tuberculosis:

1. No patient should be treated for pulmonary tuberculosis unless the diagnosis has been established unequivocally by chest roentgenograms, thorough bacteriological evaluation which should include tracheal or gastric lavage in those patients who cannot expectorate adequate amounts of sputum, and a positive tuberculin test. If the chest roentgenogram shows evidence of pathologic changes in the lung and the tuberculin test is negative, other diagnostic tests are indicated to arrive at the cause of the lung disease.
2. In all active cases of tuberculosis, treatment should be started in a tuberculous sanatorium or hospital.
3. Isoniazid should be in every drug treatment regimen. Dosage should be 5 to 8 mg/kilo or not less than 300 mg/day. In about 25% of patients with active tuberculosis a higher dosage of isoniazid is required to attain effective blood levels of their drug. In these patients 16 to 20 mg/kg/day of isoniazid is the dosage recommended. With this high dosage of isoniazid, pyridoxine in the dosage of 50 to 100 mg. per day is mandatory to prevent multiple neuritis.
4. PAS should be the routine companion drug in dosage of 12 grams daily or as close to this dose as possible. Drugs should not be stopped because of mild to moderate side effects, but continued at temporary reduced dosage.
5. Streptomycin, 1 gram daily, can be used in special cases in place of PAS but results are obtained only if the streptomycin as well as isoniazid is given daily. Intermittent (B.I.W.) use of streptomycin invites the development of resistance. Because of the possibility of permanent damage to the acoustic branch of the eighth cranial nerve, dihydro-streptomycin has no place in the present day treatment of tuberculosis.
6. In case of drug failures and relapses, other drugs may be used. These comprise a special category and are best handled in hospitals where the secondary tuberculosis drugs and surgical measures are available. The secondary drugs have a greater toxicity and require closer supervision.
7. If during out-patient treatment positive cultures continue to be obtained, the patient should be readmitted to the tuberculosis sanatorium for susceptibility studies.
8. After completion of the prescribed course of therapy (minimum duration of therapy of combined drug treatment must be at least two years) the patient must be followed by chest x-ray and sputum studies every three months for three years, after which it is recommended that the patient be followed at least yearly for the rest of his life.
9. Children through age three who are positive tuberculin reactors should be treated with isoniazid 5 mg. per kilogram per day for one year. By so doing, most serious complications of primary tuber-

culosis, that is, tuberculous meningitis, miliary tuberculosis, etc. will be prevented.

10. Recent tuberculin reactors (those who convert from a negative to a positive within a 12 month period) may be treated for one year with isoniazid.

Conclusions

The remarkable recent achievements in the chemotherapy of tuberculosis have made the treatment of tuberculosis more successful but more complex than it ever was before. The bacteriological status of the patient must be very carefully studied. The patient must be checked much more carefully for untoward reactions due to multiple drug treatment with potentially toxic agents. And, finally, if long-term therapy is to be followed conscientiously, proper motivation toward cooperation must be established in each patient. Home-care programs which were started on the basis of expediency have demonstrated that they are more successful if treatment has been initiated in a hospital.

The general principles of chemotherapy of demonstrably active tuberculosis can be summarized as follows. First, chemotherapy with two or more drugs should be initiated in adequate dosage in order to achieve the short-term goal of rapid conversion to the bacteriologically negative state. Second, early increasing physical activity should be employed, as well as other measures of preventing, if possible, the achievement of the metabolically dormant state by the organisms in the patient's lesions. Third, all measures aimed at inducing the local anaerobic state should be avoided until either the short-term goal of chemotherapy has been reached or failure is imminent. All of these measures, in most cases, require hospitalization of the patient. Fourth, protracted treatment after bacteriologic conversion, whether with one drug or more, must be uninterrupted. This aspect of therapy may be carried out as the home-care part of the management of pulmonary tuberculosis, but again proper motivation of the patient looms large in assuring success.

The implication of this review is that most of the failures of chemotherapy of tuberculosis today can be attributed to employment of therapeutic measures which are not specifically designed to take maximum advantage of their potential. The common view that the available drug regimens have only a bacteriostatic action in man is not supported by the available experimental or clinical evidence. Indeed, it can fairly be anticipated that the still significant proportion of drug-treatment failures ultimately will be recognized as failures due to inadequate dosage and indiscriminate integration of therapeutic measures.

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FINGERTIP INJURIES

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Amputation of the tactile pad of the finger tip is a common injury in manual industrial workers and in children. Treatment should be directed toward reconstruction of the injured finger in order to restore normal finger length, sensation and function. It is felt that the cross-finger flap operation will accomplish these ends in the simplest and most effective manner. Two case reports are presented.

Fingertip injuries are common. The majority of such injuries are inconsequential unless the injury involves fracture of the distal phalanx or loss of skin coverage. Simple lacerations of the pulp of the fingertip seldom are referred to the plastic surgeon. They are usually adequately handled by the family doctor. It is the purpose of this paper to discuss the approach to the more complicated injuries involving the fingertips.

Anatomy

Except for gripping, the main body of the finger serves only to position the tactile pad located on the palmer surface of the distal phalanx. These surfaces of the fingers, which are rich in Meissner corpuscles, are the so-called eyes of the hands. These highly specialized nerve endings convey the sensation of stereognosis and are found in decreasing numbers in the skin of the forearms, arm and trunk. It is for this reason that finger skin should be replaced with finger skin whenever possible.

Etiology

The most common injury involving the fingertip is the partial amputation of the skin and soft tissues of the distal half of the distal phalanx. The fingernail is frequently lost at the time of injury but the phalanx is usually not fractured. In children, this deformity is most commonly caused by the finger being caught in an automobile door. In these accidents, the fingertip is caught in the hinge side of the door on closing thus amputating the distal skin and soft tissues. As the pulp of a grape is squeezed out of its skin covering by pinching, so is the phalanx squeezed out of the amputated fingertip leaving the bone protruding from the injured surface.

In the adult, such fingertip injuries are usually involved in industrial accidents, such as those in which the finger is caught in the pulley of an electric motor or comes in contact with a power saw.

Treatment

There are three general methods of repair:

A. The method of amputating the distal phalanx and closing the skin edges is mentioned only to be roundly condemned. This method produces a short finger which is a severe disability, particularly when the involved digit is the thumb, index or middle finger.

B. Since the periosteum is usually lost from the exposed phalanx, the use of free grafts is obviated since the avascular cortical bone will not support viability in a free graft. In the occasional case in which the periosteum remains intact, free grafts (split thickness or full thickness) are not suitable resurfacing agents, since they produce a thin covering with no

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Figure 1

The cross-finger flap has been elevated from the dorsum of the middle phalanx of the adjacent middle finger.

Figure 2

The full thickness graft from the groin has been sutured over the flap donor area of the middle finger.

Figure 3

The defect of the index finger has been cleaned and the cross-finger flap turned and sutured over the defect.

padding and the graft becomes tightly adherent to the bone.

C. The procedure of choice is the use of a flap which would comprise full thickness skin, subcutaneous fat and an independent blood supply. The use of an abdominal or chest flap is undesirable for several reasons:

1. These flaps produce a finger with a crippled sensory apparatus in that there will never be any significant stereognotic sensibility present. Pain, temperature, light touch and deep sensibility will return in time but the ability to "see with the fingertips" is lost forever.

2. Immobilization of the involved extremity against the trunk of the body is required for two to three weeks, which is undesirable in the adult and all but impossible in the child. In the latter instance, a plaster cast is usually required.

3. Abdominal flaps are bulkier, differently colored and finer in texture than normal finger skin.

4. The fascial planes of the abdominal wall, being so thick, make it difficult to gauge the correct amount of subcutaneous fat to include in the flap.

It is felt by many that the use of palmer flaps simply creates a second deformity to correct the first. The donor area of palmer flaps usually have to be grafted for closure which frequently leaves a tender, relatively insensitive area in the functional portion of the hand. Leaving the donor area of the palmer flap open to granulate and heal by second intention produces a similar, only worse, deformity.

For these reasons, a cross finger flap is much to be desired in this type of finger injury, especially in children. The fascial planes are clear, the resurfacng agent is normal finger skin and it carries an independent blood supply.

Procedure

As in any other reconstructive procedure, the plan must be very carefully drawn up and outlined on the hand prior to surgery. The principle involves the elevation and immediate transfer of a flap from the dorsum of the adjacent finger. (Fig. 1). In most instances, a flap from the middle phalanx is used. The flap donor area is immediately resurfaced using a full thickness graft from the groin, (Fig. 2), and the donor area is closed by simple approximation of the skin edges. The wound of the injured finger is cleaned and the skin edges excised, if necessary, so that accurate placement of the flap can be accomplished. The flap is then turned and sutured over the defect. (Fig. 3). A bolus type dressing covers the graft. The hand is dressed and immobilized in the desired position using a simple wrap-around bandage. In the very young (newborns to 5 years), this dressing is left undisturbed until the final operation. In older patients, the graft dressing is changed and redressed after six days.

After approximately 18 days the root of the flap is released from the donor finger, trimmed and set-in to the proximal side of the defect.

Figure 4

Case 1. The tip of the right middle finger was amputated. The unfractured distal phalanx protrudes in the wound.

Figure 5

Cross-finger flap from the dorsum of the ring finger used to replace amputated tissue of the middle finger.

Figure 6

Dorsal and palmer view of reconstructed finger. The fingertip is normal in length, appearance and function. Sensation has completely returned. Crack in fingernail reveals point of amputation.

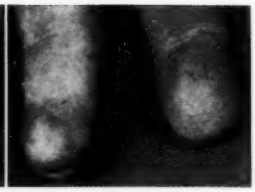


Figure 7

Dorsal and palmer view of reconstructed finger. The fingertip is normal in length, appearance and function. Sensation has completely returned. Crack in fingernail reveals point of amputation.

The root of the flap remaining on the donor finger is likewise trimmed and approximated to the graft for closure. Simple Bandaid type dressings are applied.

Case Reports

1. The patient was a 35 year old white male who caught the right middle finger in an electric motor pulley on March 19, 1957. He was seen shortly after the accident. Examination revealed that the tactile pad and fingernail of the middle finger had been incompletely amputated and the phalanx was protruding from the wound. (Fig. 4). Grease was everywhere in the wound. X-rays revealed no evidence of fracture of the distal phalanx.

Under general anesthesia, the foreign material was removed from the wound. The jagged wound edges were excised. A cross-finger flap was elevated from the dorsum of the middle phalanx of the adjacent ring finger and sutured over the defect of the middle finger. (Fig. 5). A full thickness graft, taken from the groin, was used to cover the flap donor area of the ring finger. Postoperatively the patient did very well and was allowed to return home on the second postoperative day. The sutures were removed on the seventh postoperative day and at that time the graft and flap were in good condition.

On April 8, 1957, under local anesthesia, the cross-finger flap was released from the donor finger, trimmed to fit the proximal edge of the wound of the middle finger and set-in. The root of the flap was also set-in to the graft of the ring finger. The sutures were removed after seven days and at that time healing was complete.

When last examined this patient had a normal finger in function, sensation and appearance. The fingernail has regrown and is normal in appearance. (Fig. 6 and Fig. 7).

2. A 16 months old male infant amputated the fingernail and tactile pad of the tip of the right index finger on October 28, 1957, when the finger became caught in an automobile door. Under general anesthesia, a cross-finger flap from the middle finger was used to replace the amputated tactile pad and the flap donor area was resurfaced with a full thickness graft form the groin. Because the patient was so young, the hand dressing was left undisturbed until November 15, 1957, when the flap was released and set-in to complete the surgery. When last examined on April 15, 1959, the finger was of normal length, appearance and function. As well as could be determined in so young a patient, sensation was normal.

Conclusions

The cross-finger flap procedure is the best available method of reconstructing fingertip injuries involving loss of a portion of the tactile surface. In this manner, the injured finger is reconstructed with tissue which will develop normal sensation and will withstand normal wear and tear. The procedure is done in two short operating sessions and the patient is disabled only to the extent of having a portion of one hand bandaged for approximately two weeks.

Summary

A procedure is described for the reconstruction of fingertip injuries which is peculiarly suited to such injuries in children.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Cardiac Rupture

DALE GROOM, M. D.
Department of Medicine

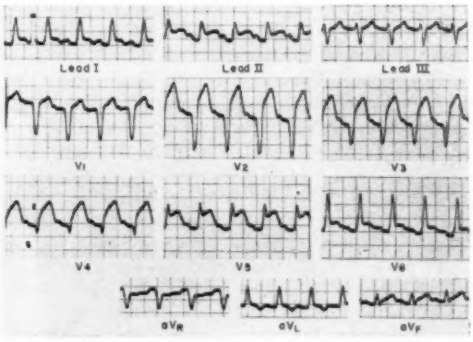
Case Record—What appeared at first to be a "good risk" case of myocardial infarction in a 68 year old lady turned out to be quite the reverse. It was her first infarction and she was admitted to the hospital within 24 hours after the onset of pain in the mid-chest and arms which did not respond to her usual recourse of nitroglycerin. Notable is the fact that she had been treated several years for hypertension.

Serial electrocardiograms were indicative of an acute anteroseptal infarction. Presumably it was not too extensive as judged by a drop in blood pressure to the neighborhood of only 120-150 systolic over 80-100 diastolic, effective relief of her pain by moderate doses of morphine, relatively little rise in her temperature, sedimentation rate or white blood cell count, and a maximum transaminase peak of 117 units. Nevertheless anticoagulant therapy was instituted at the time of admission and maintained at adequate levels.

One week later chest pain recurred, this time accentuated by respiration and associated with weakness, tachycardia and a precipitate fall in blood pressure to 80/50. It remained low the following day when this tracing was recorded, gradually declined further throughout the next day when she became comatose and died.

At autopsy 450 ml. of clotted blood was removed from the pericardial sac. Clot was adherent to the epicardial surface of the left ventricle which was covered by a fibrinous pericarditis. A soft, grayish-yellow area of infarction extended from the anterior left ventricular wall into the septum. The anterior descending branch of the left coronary artery was completely occluded by thrombus at a point 3 cm. from its origin. Adjacent to its mid portion there was a 1 cm. rent in the free wall which freely admitted a probe into the cavity of the left ventricle and obviously constituted the hemorrhagic tract. Microscopic sections from this area showed the infarction to involve virtually the entire thickness of myocardium with necrosis, early fibrosis, interstitial hemorrhage and an organizing fibrinous pericarditis. Weight of the heart was 350 grams.

Electrocardiogram—The rhythm is a regular sinus one at a rate of 125 with normal AV conduction throughout (P-R 0.18). QRS complexes are slurred



and widened to 0.10, most of the delay being in the initial portion as shown in V_6 where the intrinsicoid deflection of the R wave occurs 0.06 sec. after onset of the QRS. This is consistent with either hypertrophy of the left ventricle or some impairment in its conduction system.

As in her tracings of the preceding week, R waves are completely absent from V_1 through V_4, suggesting that the anteroseptal infarction is probably transmural. But whereas the S-T segment elevation previously had been largely confined to those leads (and had actually regressed almost to normal) now the segments are elevated in all leads except the one looking into the cavities of the heart, AVR. The reciprocal S-T depression there was not present in the earlier records. During the interim there was no significant change in QRS complexes which would indicate any further infarction.

Discussion—It is of course the case rather than the electrocardiogram which is illustrative of cardiac rupture. Essentially this tracing depicts an acute anteroseptal infarction with very prominent S-T abnormalities. While the time of rupture of the myocardium cannot be stated with certainty, several observations suggest that it occurred the previous day: the sustained drop in blood pressure with tachycardia, the advent of pain accentuated by respiration along with widespread S-T segment elevations both consistent with pericarditis, as well as the large amount of clotted blood extravasated from the slit-like tear and the microscopic evidence of organizing fibrinous pericarditis. If so, her 48 hour period of survival following the catastrophe is unusually long for rupture of the free wall of the left ventricle.

One of the major complications of acute myocardial infarction is rupture of the left ventricle into the pericardial sac or, occasionally, through the septum into the right ventricle. Probably less common than

congestive failure, shock, arrhythmias or thromboembolic complications, rupture is variously reported to account for 5 to 10 per cent of the fatalities due to coronary occlusion. Understandably it is much more prevalent among patients with hypertension. At least some of the reported increased incidence (two to three times) of this complication in cases receiving anticoagulant therapy can be ascribed to the common practice of reserving anticoagulants for the "poor risk" cases such as those with multiple, massive or complicated infarctions. Like cardiac aneurysm, rupture of the myocardium is more apt to occur in patients who do not get adequate rest during the early stage of the acute illness and hence it constitutes a strong argument for complete bed rest during at least the first two weeks following occlusion. Transmural infarcts, producing softening and necrosis of practically the entire thickness of the ventricular wall, are most prone to rupture. And for reasons unknown, site of the break is located much more often on the anterior than the posterior wall. At times it may not tear completely through, allowing dissection between layers of muscle and giving rise to a localized bulge simulating aneurysm. (Independent of cardiac rupture, minute amounts of gross blood are commonly found in the pericardium of patients treated with anticoagulants and probably account for some of the familiar fleeting pains in the chest on movement and respiration during convalescence from coronary thrombosis.)

Typically this complication arises about the seventh to tenth day after onset of infarction but can occur within the first two or three days. Pain, shock, cardiac tamponade due to hemopericardium and death within minutes or a few hours is the classical course of events. Tamponade was not noted in this patient in spite of almost double the usual amount of hemorrhage, perhaps due to a more gradual accumulation allowing time for the pericardium to dilate. Hence the diagnosis was not made ante mortem; indeed if it had been, this patient might have been considered for surgery. In a few cases such a lesion is conceivably operable as is rupture of the aorta. In retrospect, a bedside chest film showing a gross increase in cardiac size might have been helpful in differentiating rupture of the myocardium from perhaps the more likely clinical diagnosis, extension of the previous infarction.

Alcoholic cardiomyopathy—W. Evans. Amer Heart J—61:556 (April) 1961

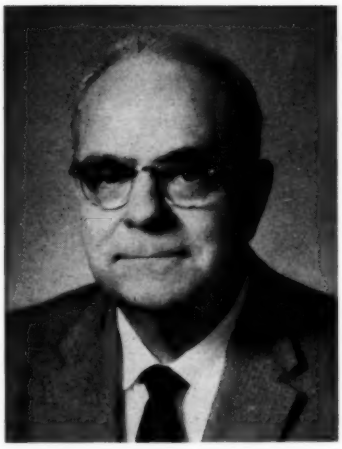
The patient with alcoholic cardiomyopathy is usually a middle-aged man. He is often overweight, and this is generally accepted as the cause of his moderate breathlessness, which is the common presenting symptom of alcoholic cardiomyopathy. If palpitation should be the chief complaint, extrasystoles may be discovered in addition to moderate tachycardia, or the arrhythmia may take the form of auricular fibrillation. Slight enlargement of the heart may be detected roentgenographically. Electrocardiography (ECG) is valuable. During the early phase it will reveal some form of arrhythmia, like extrasystoles from diverse foci. The T waves are deformed, presenting a spinous, cloven, or dimple design, patterns which are not seen in the ECG of coronary heart disease. Recognition of alcoholic cardiomyopathy at this stage is rewarding, because abstinence from alcoholic drinks can halt the march of fibrosis. When the diagnosis is missed, and the patient does not abstain from alcohol, more prolific myocardial fibrosis will develop and signs of heart failure make their appearance. These include a prominent venous pulse, systolic murmurs from mitral and tricuspid regurgitation, triple heart rhythm, cardiac enlargement, pulmonary congestion, hepatic distention, and edema. The ECG changes become more obvious, and the earlier distinctive T-wave patterns are submerged either by an arrhythmia, bundle branch block, complete heart block, or by a more frank inversion of the T. Alcoholic cardiomyopathy is often not recognized until it reaches a stage at which the myocardial fibrosis cannot be halted or improved.

Experiences with relaxant drugs in cerebral palsy: 1949-1960—E. Denhoff and R. H. Holden. New Engl. J. Med.—Vol. 264:475 (March 9) 1961.

A 12-year program of relaxant drug research in cerebral palsy is reviewed. Requirements for a relaxant drug are stated, and the importance of noting behavioral as well as neuromotor effects is stressed. Standardized methods of assessment and experimental procedures are described. In 4 of 8 drugs studied, placebo effect was greater than drug effect. Before indiscriminatingly accepting a new drug as beneficial in cerebral palsy, neuromotor and behavioral effects should be rigidly evaluated against placebo responses. Conclusions as to relaxant drug therapy must be made with caution until more objective methods of measurement are available.

Innocent murmurs, Dale Groom, M. D. (Charleston) South. M. J. 54:253-256 (March 1961).

The differentiation of innocent from pathologic murmurs can be a most difficult decision, one which is not reducible to any simple set of rules. Certainly all systolic murmurs of more than moderate intensity and all diastolic ones are not necessarily indicative of heart disease. Nor are all faint ones benign—obviously the loud murmurs of advanced valvular disease are, in early stages, of comparably low intensity. Usually the decision entails consideration of the sound in the light of the patient's history and other clinical findings. It is one of "clinical judgment". As in the case of the accomplished musician who perceives more of the music he hears than does another, the training and experience of a physician weigh heavily in his evaluation of a murmur.



President's Page

The meeting of the American Medical Association in New York the latter part of June should be watched by all members of the Association. Many decisions will have to be made by the House of Delegates, and it should be a workshop session. We, in this state, should be very much at ease in that we have two experienced delegates to represent us at this meeting.

There will undoubtedly be a lot of discussion of the pending legislation in Congress, and certainly some type of strategy will be mapped out for the county and state societies to go by. It is hoped too that South Carolina will be more in the spotlight during and after this gathering.

Meeting in New York, there should be a large attendance, and for those who have never attended a meeting of the largest medical association in the world, it should be a MUST at least once. The question has often been asked, "What does the American Medical Association do"? Well, the attendance at one meeting will go a long way in answering this question. Certainly a tremendous amount of work is turned out by the AMA.

We would like to see a goodly number of doctors from this state at this meeting.

Charles N. Wyatt, M. D.

Editorials

YOUR OWN PUBLIC RELATIONS

Traditionally the medical profession, collectively and individually, frowns upon any form of advertising and its urbane cousin—Public Relations.

Today there is an urgent need to revise this feeling and to meet the growing need for the creation of a public image. This ten dollar Madison Avenue word has been over-worked and maligned. In its true context it means the presentation of a clear, concise and accurate view of a given profession to those who are non-members or laymen.

Leo Brown, Director of the Communications Division, American Medical Association, once defined the image or the public relations of the medical profession as "the mind's eye interpretation of the medical profession, as reflected in the mirror of public opinion." Today it is urgent that this mirror reflect a favorable picture.

Because of recent political maneuverings the medical profession in the United States faces the peril of appearing before the public with a muddied reflection. Worse still is the risk that we will wake up some day soon to discover that our medical profession has been socialized by dangerous Forand-type legislation.

Political pressure groups are continuing to urge Congress to sneak an insidious form of socialized medicine through the back door of "Social Security."

The fallacies in this plan, and the back-breaking load it would place on the incomes of many generations of taxpayers are not difficult to find *if* one takes the time to make a brief and thoughtful study. Unfortunately not everyone takes the time to understand.

All too often public opinion is shaped by popular images which have been distorted and colored to the specifications of welfare staters whose chief interest is public job holding. Such distortions are being made about our time honored profession every day.

Fortunately we do have many friends at court in the conservative, knowledgable legislators who — working closely with the American Medical Association — blocked the disastrous Forand Bill and passed in its stead the Kerr-Mills Medical Aid for the Aged law last summer.

This single victory did not defeat the protagonists of the Forand Bill. The war will continue. If the medical profession is to win a final victory we must work consistently and diligently, each on his own battlefield. The battlefield is in your community. It is to you that friends, business associates and patients look for their impressions of the American Medical Profession. It is for them that we must create a clear and accurate picture of medicine today. It is up to us to show them the whole picture, not a splash of color in one isolated corner.

We are depending on each of you to help in the creation of this unclouded image by replacing loaded propaganda with facts.

You can make these facts known through daily conversations with your friends, neighbors and business associates. You can help by taking a few extra minutes to see that your patients have received—through your office—some of the excellent pamphlets on medical care legislation prepared by the American Medical Association. (These pamphlets are available in any quantity through the office of the public relations chairman of the South Carolina Medical Association.) You can impress upon your patients the need to read and study these phamphlets so that they may formulate their own opinions.

Finally, you can help by taking an active part in your county medical society's activities —such as the speakers bureaus now in existence in 21 county societies.

There is no time to lose. The ammunition is considerable but it will serve no purpose if it remains silently in the magazine.

J. M.

THE STINGING SEASON

The universal fear of poisonous snakes—in fact of snakes of any kind by most people—has overshadowed the danger which is present in the poisonous sting of bees, wasps, and spiders. Figures compiled a few years ago show that bites from these insects were more dangerous in point of mortality than were those of snakes. While 71 deaths from snake bites were reported, 85 occurred from stings from various bees, wasps, hornets, etc., and 39 resulted from the bites of poisonous spiders. Probably these figures are not accurate and probably are too low, and also it is likely that many deaths attributed to other conditions such as heart attack, were actually due to the poisonous bite.

Death from bites of these insects is often very rapid, and results from either a shock reaction or pronounced allergy in the victim.

Promising efforts are in progress to develop an immunizing substance for those people who are likely to be stung or who are known to have severe reactions to bites. This seems to be still in the process of investigation, but offers some preventive measures for the future.

For years, you've been exhorted to take a greater hand in A.M.A. affairs. But the greatest hand at the A.M.A.'s recent midwinter meeting went to a doctor who dared to suggest that his committee's affairs weren't worth your attention. Here's the entire report of Dr. George D. Johnson, chairman of the Reference Committee on Sections and Section Work:

"Mr. Speaker and members of the House of Delegates: The committee met. There was no business to transact. We wish to thank all those who did not appear. The committee felt that it was a most successful meeting and, having no business to attend to, promptly adjourned. Mr. Speaker, I move the adoption of the report as a whole."

Dr. Johnson's motion was quickly carried—with acclamation.

Medical Economics

Pills, Poetical and Philosophical Prescribed for the Purpose of Purging the Public of Piddling Philosophies, of Puny Poetasters, of Paltry Politicians, and Petty Partisans By Peter Pepper-Box, Poet and Physician.

—Charleston Courier
January 3, 1810

REPEATERS

While the editor does not presume to pose as a grammarian, he is still entitled to view with alarm some of the oddments of writing that continue to creep into a fairly permanent place in the current medical usage. Undoubtedly some of the queer expressions originate in the fertile but ungrammatical brains of medical students and house officers, transfer themselves to the attending staff, and eventually are off for the press, especially for those journals whose editors do not quibble at minor peculiarities of writing.

Today's alarmed view is on the subject of the word "repeat" which seems to be assuming an adjectival character which the most corpulent dictionaries do not endorse. "A repeat urinalysis," "a repeat blood count," probably evolved from the admonition to "repeat the urinalysis," or "repeat the blood count," and became examples of a variant of the popular pastime of verbalizing nouns (e.g. "to cystoscope"). "Repeat" in this usage appears currently in some otherwise estimable journals. For the sake of the language it might better be scotched before repeat is repeated too repeatedly to avoid a "repeat" and established repetition.

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Dr. Donald G. Kilgore, Jr. — 1961-64—3 yrs.
100 Mallard St.
Greenville

Dr. Henry L. Lafitte — 1961-63—2 yrs.
Allendale

Ex-Officio:

Dr. Charles N. Wyatt
301 E. Coffee St.
Greenville

Mr. M. L. Meadors
309 W. Evans St.
Florence

Dr. Robert Wilson
165 Rutledge Ave.
Charleston

COMMITTEE ON MEDICAL AND HOSPITAL INSURANCE

Dr. Joseph P. Cain, Jr., Chr.
411 S. Main St.
Mullins

Dr. Clay W. Evatt
93 Rutledge Ave.
Charleston

Dr. Kenneth Lawrence
307 W. Palmetto St.
Florence

COMMITTEE ON RURAL HEALTH

Dr. Robert H. Burley, Chr.
100 Sloan St.
Clemson

Dr. Swift Black
110 W. Harrison St.
Dillon

Dr. A. Richard Johnston
St. George

Dr. Hugh W. Mole
Sixth St.
Denmark

ADVISORY COUNCIL TO WOMAN'S AUXILIARY

Dr. Richard W. Hanckel, Chairman
Charleston

Dr. J. Decherd Guess
200 East North Street
Greenville

Dr. O. B. Mayer
1220 Pickens Street
Columbia

THE COMMITTEE ON REHABILITATION

Dr. Harry Mims — 1961-65—4 yrs.
55 Doughty Street
Charleston

Dr. Ben Miller — 1961-66—5 yrs.
1433 Gregg Street
Columbia

Dr. John K. Webb — 1961-64—3 yrs.
12 South Calhoun Street
Greenville

Dr. Charles B. Thomas — 1961-62—1 yr.
701 Pendleton Street
Greenville

Dr. Roderick Macdonald — 1961-63—2 yrs.
330 East Main Street
Rock Hill

COMMITTEE FOR THE CARE OF THE AGED

Dr. R. L. Crawford, Chr.
229 South Main Street
Lancaster

Dr. John A. Boone
55 Doughty Street
Charleston

Dr. Thomas Parker
110 South Calhoun Street
Greenville

Dr. Martin Teague
501 South Harper Street
Laurens

COMMITTEE ON MEDICAL EDUCATION FOUNDATION

Dr. Howard Stokes, Chr.
161 W. Cheves St.
Florence

Dr. Thomas Gaines
126 E. Earle St.
Anderson

Dr. Vince Moseley
55 Doughty St.
Charleston

MEDICAL ADVISORY COMMITTEE TO THE CRIPPLED CHILDREN'S SOCIETY OF SOUTH CAROLINA

Dr. J. I. Waring, Chairman — 1961-63—2 yrs.
82 Rutledge Ave.
Charleston

Dr. William Weston, Jr. — 1961-63—2 yrs.
1515 Bull St.
Columbia

Dr. John A. Siegling — 1961-63—2 yrs.
70 Ashley Ave.
Charleston

Dr. John E. Keith — 1961-63—2 yrs.
201 Professional Bldg.
Spartanburg

Dr. O. B. Mayer — 1961-63—2 yrs.
1220 Pickens St.
Columbia

Dr. Frank H. Stelling — 1961-62—1 yr.
9 Medical Court
Greenville

Dr. J. W. Jervey — 1961-62—1 yr.
709 Dunbar St.
Greenville

Dr. Harry W. Mims — 1961-62—1 yr.
55 Doughty St.
Charleston

Dr. C. Guy Castles, Jr. — 1961-62—1 yr.
1417 Gregg St.
Columbia

Dr. Walter M. Hart — 1961-62—1 yr.
248 South Irby St.
Florence

Dr. Angus Hinson — 1961-64—3 yrs.
1057-59 Oakland Ave.
Rock Hill

Dr. Anthony White — 1961-64—3 yrs.
Professional Bldg.
Easley

Dr. Harry S. Allen — 1961-64—3 yrs.
220 S. Irby St.
Florence

Dr. William F. Prior — 1961-64—3 yrs.
Graniteville

Dr. William A. Klauber — 1961-64—3 yrs.
Self Memorial Hospital
Greenwood

MEDICAL ADVISORY COMMITTEE TO SELECTIVE SERVICE

Dr. Frank Owens, Chairman
1319 Laurel St.
Columbia

COMMITTEE ON INDUSTRIAL MEDICINE

Dr. George C. Smith, Chr.
311 W. Palmetto St.
Florence
Dr. W. W. Edwards
103 E. North St.
Greenville
Dr. John M. Perry, Jr.
Sonoco Products Co.
Hartsville
Dr. Murray T. Jackson
Conway Hospital
Conway

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Dr. J. I. Waring, Chr.
82 Rutledge Ave.
Charleston
Dr. R. M. Pollitzer
304 E. North St.
Greenville
Dr. T. A. Pitts
1519 Marion St.
Columbia
Dr. James R. Young
134 E. Earle St.
Anderson
Dr. Wilbur R. Tuten, Sr.
Fairfax

COMMITTEE ON CORONERS-MEDICAL EXAMINERS

Dr. E. Arthur Dreskin, Chr.
100 Mallard St.
Greenville
Dr. D. Strother Pope
1116 Henderson St.
Columbia
Dr. J. I. Converse
413 N. Main St.
Greenville
Dr. C. Tucker Weston, Jr.
1410 Barnwell St.
Columbia
Dr. Robert P. Walton
16 Lucas St.
Charleston

LIAISON COMMITTEE BETWEEN SOUTH CAROLINA MEDICAL ASSOCIATION AND THE DEPARTMENT OF PUBLIC WELFARE

Dr. Harold S. Pettit, Chr.
55 Doughty St.
Charleston
Dr. E. Kenneth Aycock
1515 Bull St.
Columbia
Dr. R. Brooks Scurry
Scurry Clinic
Greenwood
Dr. Frank F. Espey
123 Mallard St.
Greenville
Dr. Ripon W. LaRoche
406 Laurens St.
Camden
Dr. L. D. Lide
151 W. Cheves St.
Florence
Dr. Wallis D. Cone
206 N. Sumter St.
Sumter
Dr. V. Wells Brabham
950 Holly St.
Orangeburg
Dr. William T. Hendrix
408 Andrews Building
Spartanburg

COMMITTEE ON LIAISON WITH ALLIED PROFESSIONS

Dr. Harold E. Jervey, Chr.
1515 Bull St.
Columbia
Dr. John W. Blanton, Jr.
Alabama St.
Chesnee
Dr. Delmar O. Rhame
Hays Hospital
Clinton
Dr. Hugh H. Wells
North First St.
Seneca
Dr. Robert E. Quinn
1530 Highmarket St.
Georgetown

COMMITTEE TO STUDY CURRENT EFFORTS AND FACILITIES OF THE AMA ALONG PUBLIC RELATIONS LINES

Dr. Joseph I. Waring, Chr.
82 Rutledge Avenue
Charleston
Dr. Robert L. Crawford
229 South Main Street
Lancaster
Dr. Wallis D. Cone
206 Sumter Street
Sumter

COMMITTEE TO STUDY INJURIES FROM LEAD PELLETS

Dr. J. W. Jervey, Chr.
709 Dunbar Street
Greenville
Dr. David S. Asbill
1417 Barnwell Street
Columbia
Dr. Pierre G. Jenkins
155 Wentworth Street
Charleston

COMMITTEE FOR ACCIDENT PREVENTION

Dr. Henry Moore, Chr.
1417 Gregg St.
Columbia
Dr. James B. Berry
Marion
Dr. O. B. Mayer
1220 Pickens St.
Columbia
Dr. L. W. Blackmon
1420 Lady St.
Columbia
Dr. William R. DeLoach
13 Medical Court
Greenville
Dr. Casper Wiggins
Medical Arts Bldg.
Greenwood
Dr. Margaret Jenkins
55 Doughty St.
Charleston

ERRATUM

In the June issue the list of the Executive Committee of the Council and the Committee on Emergency Medical Care was included erroneously with an item concerning the Alumni Association. The list is repeated below:

EXECUTIVE COMMITTEE OF COUNCIL

Dr. John M. Brewer, Kershaw, chairman
Dr. Alfred F. Burnside, Columbia, vice-chairman
Dr. William L. Perry, Chesterfield, clerk

COMMITTEE ON EMERGENCY MEDICAL CARE

Dr. William C. Herbert, Jr., Spartanburg—1-yr. term
Dr. Charles R. May, Bennettsville—2-yr. term
Dr. J. Graham Shaw, Columbia—3-yr. term
Dr. Robt. S. Solomon, Moncks Corner—4-yr. term
Dr. Raymond E. Ackerman, Bethune—5 yr. term

THE NEXT SCIENTIFIC PROGRAM

The scientific sessions of the annual meeting of the South Carolina Medical Association will be held on 9 and 10 May 1962 at Myrtle Beach. The following paragraph is an appeal for the membership to take an active and constructive interest in the development of the program. Please note, especially, the request for abstracts of papers which members of the Association may present.

The Program Committee of your Association is now hammering away to produce a scientific session which is calculated to arouse your interest, supply your intellectual needs, and invite your participation. In order to fulfill the first of these objectives, your Committee would appreciate suggestions as to topics and technics of interest to you. To aid in the second category, your Committee would welcome specific names of speakers of unusual talent, both from among the membership as well as from the profession elsewhere. The third objective may be the most rewarding of all. The Committee earnestly requests that as many as may accept the challenge submit abstracts of 100 to 300 words in length of proposed papers which might be presented during the scientific sessions. It is hoped that many will be submitted so that those specifically suited to the overall tenor of the program may be selected. It is the Committee's desire that not less than three papers, 15 to 20 minutes in length, may be scheduled from this source. These abstracts should be in the hands of the Program Committee not later than 1 September 1961. You will then have eight months in which to polish up the details. Give it a try! Be reminded, chances are your schedule will not become less busy; your time will not become less dear; DO IT NOW!

Forde A. McIver, M. D., Chairman
Program Committee
16 Lucas Street
Charleston 16, S. C.

Correspondence

Friday, May 26, 1961

To The Editor:

In the last 48 hours two patients referred to the Medical College Hospital for dialysis on the artificial kidney have died in the ambulance on the way to the hospital. In the last four weeks two other patients have died so shortly after reaching the hospital that nothing could be done for them.

These four deaths in such a short period of time indicate a need to set forth once again certain ideas about the use of extra-corporeal dialysis in the treatment of renal failure. Even though the mortality rate for those undergoing dialysis (the unfavorable group who probably would not survive conservative treatment) is above 50%, those patients salvaged represent a worthwhile accomplishment.

The perfection of many technical advances has made efficient dialyzing units widely available. There has been a formidable body of experience with these units accumulated in the past few years. Groups of physicians working with these units are almost unanimous in saying that their early and frequent use in the course of renal failure will result in much higher salvage rates than expectant treatment of very ill patients. Although the uremia and hyperkalemia of conservatively treated, acute renal failure can be ameliorated by hemodialysis even late in the course of the episode, the accompanying complications of shock, bronchopulmonary infection, bacteriuria, severe anemia, pyelonephritis, gastrointestinal hemorrhage, cardiac failure, a variety of toxic psychoses, etc., which accompany this form of uremia make the survival of patients who have been allowed to become densely uremic problematic.

Therefore, some revision of many widely held ideas about the use of dialyzing units is in order. The use of extra-corporeal dialysis should not be looked upon as a last ditch heroic measure to attempt to save a dying patient. Rather, when oliguria becomes manifest, consideration of the place of hemodialysis in the treatment of such patients should begin immediately. Experience indicates that individuals with no urine output, or urine output of less than 200 ml. per 24 hours, will more probably need to be dialyzed than not. The presence of high fever, a broncho-pulmonary infection, jaundice, or severe anemia, or the post-operative state remarkably increase the likelihood that dialysis will be needed. Dialysis is much more often

necessary in post-partum patients than in any other group. It should also be remembered that individuals who are post-traumatic and have large amounts of either infected, bloody, or macerated tissues retained in the body are more apt to require dialysis.

Accordingly, the hemodialysis team at the Medical College Hospital recommends to the profession at large in the state that patients with actual or suspected acute renal failure be referred for hemodialysis within 48 hours of the emergence of renal failure. Although this policy will result in the unnecessary referral of some patients, it will doubtless eventuate in the survival of some such as those whose deaths have occurred in the last month.

In summary, it can be stated that the technique of hemodialysis has been perfected so that it can be undertaken as something less than a desperate emergency procedure. Anuria or severe oliguria in ill patients is tolerated for a very short period of time. Early referral to a center where a hemodialysis unit and team are available will eventuate in the salvage of the lives of a significant group in whom the so-called conservative management can be predicted to fail.

Cheves McC. Smythe, M. D.
Arthur V. Williams, M. D.
John Buse, M. D.

BLUE CROSS . . . BLUE SHIELD

The medical profession in 1960 received more than $731,000,000 from the 74 nationwide Blue Shield Plans for care rendered members, the National Association of Blue Shield Plans reported recently.

"The $731,131,187 paid to physicians represented an all-time high for a one-year period, and also represented nearly 90 percent of the total 1960 income of these medical-surgical Plans," John W. Castellucci, executive vice president of the national association, stated. At the same time, the Blue Shield Plans devoted less than 10 per cent of their total 1960 income to administrative expenses.

In its report, the national association indicated that Blue Shield payments to the medical profession had increased from nearly $116,000,000 in 1950 to the 1960 figure of $731,131,187.

"The impressive increase in payments to the medical profession over the years on behalf of Blue Shield members clearly reflects the ability of these medical-surgical Plans to develop realistic and flexible programs in order to keep pace with the tremendous advances in our medical care system," Castellucci added. "At the same time," Castellucci concluded, "our Plans have annually expended a lesser percentage of their income dollar to administrative expenses in the face of spiralling inflation and the commensurate cost of doing business."

Enrollment in the nationwide Blue Shield Plans surpassed the 47,000,000 member mark at the end of 1960, the National Association of Blue Shield Plans reported recently. Total membership in the 74 medical-surgical Plans reached 47,084,988 on December 31, 1960, representing an enrollment of one out of every four Americans, and nearly 15 per cent of the total Canadian population.

The national association also reported that four Blue Shield Plans have enrolled more than 60 per cent of the population in the areas they serve. They are the Plans serving the District of Columbia, Rhode Island, Delaware and Rochester, N. Y., areas.

News

DR. LUCIUS VARN BEGINS PRACTICE IN BRANCHVILLE

Dr. Lucius Varn has returned to his home town to practice medicine.

Branchville had been without the services of a resident physician for six months until Dr. Varn opened his office here recently. He had done general practice in Orangeburg since 1957 in addition to serving as director of the Orangeburg County Health Department. He will continue in the latter capacity in his new location.

A native of Branchville, he was graduated from the local high school, Newberry College and the Medical College of South Carolina. He interned at Orangeburg Regional Hospital. He received the Master of Arts Degree in Public Health from the University of North Carolina in June.

Dr. Louis M. Stephens, a 1960 graduate of the Medical College of South Carolina, has received a $1,000 scholarship toward a general practice residency in Alexandria, Louisiana. The award is one of 20 conferred by Meade-Johnson Drug Company on doctors serving general practice residencies throughout the country.

Dr. Robert S. Watkins of Camden has been appointed a member of the Board of Trustees of the State Sanitarium by Governor Hollings.

Dr. Watkins is the Fifth Congressional District's representative on the Board, and his appointment is for four years.

Dr. O. Norman Evans of Greenville has moved to Seneca to become associated with Dr. Lane Mays and Dr. H. H. Wells in the Medical Clinic.

Dr. Evans interned at Greenville General Hospital. He is a graduate of the Medical College of South Carolina, class of 1959. He is a graduate of Furman University. He served in the Navy during World War II and from 1950-56 he was a Captain in the U. S. Army, serving as a clinical psychologist.

Dr. C. R. F. Baker of Sumter was elected to the presidency of the South Carolina Surgical Society at its meeting May 18-21 at Sea Island, Ga. He succeds Dr. William Brockington of Greenwood at the helm of the 73-member group.

Dr. M. U. Dantzler of Charleston was elected president of the South Carolina Association of Public Health physicians at a medical section meeting held in conjunction with the 38th annual convention of the South Carolina Public Health Association in Greenville in May.

Dr. Hilla Sheriff of Columbia was elected vice president, and Dr. L. A. Nimmons of Bishopville was named secretary and treasurer.

The new officers also will serve as officers of the medical section of the Public Health Association.

Dr. Sidney A. Garrett, 33, of Pickens, S. C., a general practitioner and surgeon, will join Dr. Morris Dalton of Hartwell, Georgia, in practice in July. Dr. Garrett was graduated from the Medical College of South Carolina in 1955.

Colleton County Medical Society

The Colleton County Medical Society has joined the ranks of county societies accepting the task of organizing and training personnel to make available emergency medical service to the citizens of their community. Medical teams specially trained and highly mobile will soon be formed in Colleton County to provide emergency medical care for disaster victims.

Dr. Cuttino Receives LL.D.

Dr. John Tindal Cuttino, acting president of the Medical College of South Carolina, was awarded the honorary degree of Doctor of Laws by his alma mater, The College of Charleston, at its 176th annual commencement on May 30. Dr. Cuttino was graduated from the Medical College of South Carolina in 1936 and after an internship at Roper Hospital he went into his chosen field of pathology, first at the South Carolina State Hospital, then at St. Elizabeth's Hospital in Washington, D. C., and after his army service 1941-46, on the teaching staff in the Department of Pathology at Duke. Dr. Cuttino came to the Medical College of South Carolina in July 1950 as associate professor of pathology and acting dean. He was made acting president in 1960-61.

Dr. T. G. Goldsmith

Dr. Thomas G. Goldsmith of Greenville was nominated to succeed himself as treasurer of the Association of American Physicians and Surgeons at one of its best attended Interim Meetings at the House of Delegates in Chicago in April. Nominees will be voted on by the AAPS Assembly which meets in Asheville, North Carolina, on October 12, 13 and 14, 1961.

Dr. J. T. Green

Dr. and Mrs. J. T. Green of Elloree celebrated their golden wedding anniversary recently. Dr. Green was graduated in 1909 from the South Carolina Medical College and two of his classmates, Dr. L. A. Hartzog of Olar and Dr. W. T. Brockman of Greenville, participated in the celebration.

Dr. Robert Black

Dr. Robert Black of Bamberg, together with his fellow townsman B. D. Carter, were featured in a recent article in the *Augusta Chronicle*. Mr. Carter, a lawyer of eighty years, and Dr. Black, now a venerable 79, were described as men who refuse to grow old. Dr. Black was graduated from the Medical College of South Carolina in 1905 and has an extensive medical practice in his home town, where he also operates a drug store. In spite of his years Dr. Black is president of the Bamberg County Bank and the Edisto Building and Loan Association, is active in public affairs, is an active Mason and member of the First Baptist Church, the Lions Club and Men's Garden Club. A few years ago he made a trip around the world and continues to keep young by fishing, hunting and traveling.

MEDICAL SOCIETY ENDORSES POISON CONTROL PROGRAM

The Charleston County Medical Society has endorsed a proposed two-year educational program for the prevention of accidental poisoning of children.

A joint effort of the County Health Department, the pediatric department of the Medical College Hospital and the State Board of Health, the program has been discussed at a series of preliminary meetings.

The United States Public Health Service also is

interested in the program as a pilot project in the field of poisoning prevention.

A spokesman for the planning committee pointed out that 70 per cent of poisonings occur because poisons are available to children and that, in an attempt to reduce this incidence, it is necessary to educate and alert parents to this fact.

Aimed primarily at parents of children five years of age and younger, the educational program will make use of many media.

Aside from newspapers, television and radio, which the committee feels will reach only 10 per cent of the people involved in or concerned with the problem, such methods as addressing PTA and church groups and holding clinics and demonstrations are planned.

The committee plans to lay the groundwork for the two-year project this summer and commence the actual program in September.

HOSPITAL OBTAINS SUPPLY OF RADIUM FOR TREATMENT

Through the efforts of Dr. T. A. Campbell, Jr., local radiologist, 105 milligrams of radium and the necessary applicators have been obtained by the Cherokee County Memorial Hospital for the treatment of cancer.

Dr. Campbell, who completed his residency in radiology at the Medical College Hospital in Charleston, successfully conducted a drive for funds amounting to $3,300. He found splendid cooperation among citizens and business firms around the county.

Patients in this county will be able to obtain treatment for certain malignancies which can be benefitted by the use of this type radiation without going out of town. This is another service which the local hospital is offering the public.

MEDICAL COLLEGE GRADUATES 118

On June 1, degrees were conferred on 118 graduates of the Medical College of South Carolina in commencement ceremonies marking the 137th anniversary of the school.

Dr. John Roderick Heller, president of the Memorial Sloan-Kettering Cancer Center, delivered the main address entitled "Medicine of the Future".

John Tindal Cuttino, acting president of the college, conferred degrees and honors and Dr. Thomas Antley Pitts presented the diplomas.

The Rev. Frank DuBose, pastor of the First Methodist Church of Easley, gave the invocation.

Dr. H. Rawling Pratt-Thomas, dean of the School of Medicine, Dr. Frederick William Kinard, chairman of the committee on graduate studies, Dr. William Allen Prout, dean of the school of pharmacy, and Miss Ruth Chamberlin, dean of the school of nursing, presented candidates for oaths, pledges and degrees.

Candidates for doctor of medicine:

Joel William Allgood, Richard Henry Bendt, Wesley Lamar Betsell, Jr., Maxcy Carroll Boineau, William Lester Brannon, Jr., Algie Curry Brown, William Lucas Burns, Jr., Henry Blakely Burton, Harvey Eugene Butler, Jr., Thomas Raymond Byrd, Sydney Earl Carter, Fountain Stewart Clare, III, John De Vore Compton, Jr., Lollice Bradford Courtney, Joseph Henry Cutchin, Jr., Clarence Sylvester Davis, Jr., James Dickerson Dennis, Carla Frances DuBose, William Eugene Dukes, Julian Baynard Ellis, Jr., Skottowe Bellinger Fishburne, Joseph Francis Flowers, William Henry Granger, Casual Donald Hammond, Alexis Connor Higgins, John Paul Jackson, Jr., Robert Edward Jackson, William Pinckney Kay, Jr., George Epps Lipscomb, James Franklin Martin, Sloan Pruitt Martin, Jr., Julian Lorin Mason, Jr., Bradwell Rustin McAlister, Ann Burgess McIntosh and Edwin Mc Tyeire Meares, Jr.

Also, Hiram Burnard Morgan, Jr., John Robert Morris, Richard Leland Morrison, III, Danielle Villeneuve Mutty, David Wyatt Aiken Neville, Jr., Walter Monroe Newton, Jr., Benjamin Edward Nicholson, George Hancock Nutt, Daniel Rembert Pace, Lucius Crawford Pressley, Jr., Thomas Pinckney Rutledge Rivers, Harold Eugene Ross, John Elliott Rowe, III, Lawton Harris Salley, Jack Monroe Smith, William Knox Stacy, Jr., Alva Lawton Strickland, Edgar Ellis Strong, III, Joseph Taliaferro Taylor, III, Barbara Anne Threatt, Eugene Theodore Tragus, Wiley Herbert Turner, Jr., Richard Edwards Ulmer, Norman Sinkler Walsh, John Logan Ward, William Franklin Ward, Jr., Thomas Baker Warren, Jr., Sidney Henry Westbrook, Jr., Robert Lee Wingate, Jr., Donald Jerome Wright and Margaret Louise Wyatt.

Candidates for doctor of philosophy degrees:

Earl Edward Aldinger, Raymond Leo Henry, Leslie Boush Reynolds, Jr. and Edward Staniforth Otey.

Candidates for Master of Science degrees: James Leonard Butterfield.

Bachelor of Science in Pharmacy degrees were granted:

James Ryeson Carroll, Jr., Gary Stanley Cooper, Charles Michael Finucan, Ronald Edward Kearse, Charles Henry Peacock, Richard Fielding Poole, Ned Allen Thomas, Faye Parsons Todd and Deidreich Petermann Von Lehe, Jr.

Graduate Nurse diplomas were awarded:

Sylvia Loy Ammons, Stella Merle Bailey, Dolores Edilene Buford Baldini, Anne Emerson Ballard, Mary Elizabeth Baxley, Jane Elizabeth Beach, Joyce Lillian Blakeney, Eva Wayne Brumfield, Allison DuBose Cantley, Julia Lillian Peeples Causey, Dorothy Marie Chandler, Norma Hazel Clardy, Elizabeth Irene Dority, Doris Evelyn Boiter Duncan, Dorothy Estelle Eadon, Nadine Willena Eldridge, Barbara Ann Elsey, Helen Marguerite Creech Garrett and Laura Jo Grissom.

Also, Carolyn Marcelene Ham, Rebecca Stackhouse Hargrove, Jackie Elizabeth Lavigno, Geraldine Claire Main, Mary Carolyn Martin, Linda Jean Miller, Rita Louise Pink Moore, Nancy Louise Moorer, Rosina Elizabeth Wood McConnell, Ann Legare O'Hear, Carol Anna Parker, Diane Morton Ryan, Katherine Woodfin Wallace Seabrook, Patricia Lee Stogner,

Sandra Louise Stumpf, Paula Claire Trussell, Rebecca Elizabeth Wallace, Helen Elizabeth Williams and Mary Idella Woods.

The New Research Building at the Medical College is started.

MEDICAL COLLEGE BUILDING

Final contracts for the construction of a Research-Clinic Building were signed in June by Dr. Thomas A. Pitts, Chairman of the Board, and Dr. John T. Cuttino, Acting President, of the Medical College of South Carolina. Total construction costs amounted to $1,168,639 in the contracts with W. C. King & Sons of Sumter, general contractors, and the Otis Elevator Company. Funds were obtained from tuition revenue bonds as approved by the State Budget and Control Board with an equal amount obtained from the Public Health Service through its Hill-Burton and Health Research Facilities agencies.

This eight story Research and Clinic Building will be served by an electrically driven, centrifugal type air-conditioning unit of 140 tons capacity with a distribution system specially designed for medical research conditions. Possible spread of air contamination between different working areas is minimized by forcing fresh, filtered, dehumidified air into each room and exhausting the air through duct systems which empty on the roof. Temperature control operates through thermostats individually adjusted in each room to regulate the flow of chilled or heated water through pipe coil units over which intake air is forced. The same pipe coils carry either chilled or heated water depending on the seasons and the switch-over system is controlled automatically by temperatures outside the building. Special air exhaust systems operate in areas where there are sterilizers, steam cage washers, radioisotope hoods, autopsy facilities and film processing. In the color film processing tanks, the water is thermostatically regulated within a variance of a half degree. Refrigerated work rooms are on the upper floors.

Some of the latest developments in the use of polyester plastics, stainless steel and low expansion coefficient glass have been incorporated in the plans. Unusual electrical capacity is provided by copper bars rising in a central utility area to all floors, from which heavy wires make 10,000 watts available in each room. Considerable power input of this type is needed because most modern research instruments are electronically operated. Overhead twist lock outlets with heavy electric cords from the ceilings permit movable electric instrumentation in any part of the rooms. An x-ray facility is located on the clinic floor and another on the animal surgery floor. Two rooms are electrically shielded for electro-encephalography recordings. Some of the examining rooms are completely panelled with sound absorbent materials. The laboratory rooms are equipped with 2 systems of electric circuits with multiple outlets and one or more stainless steel sinks with all-purpose utility desks and cabinets. Each floor has an individually adjusted hot water system making for economical and flexible operation. An area has been tentatively designed for the operation of electron microscopy but it has been experience in other similar installations that the necessary low vibration characteristics cannot be fully predicted before the building is completed. The concrete framework of the present building is expected to favor relative freedom from disturbing vibrations. General planning has aimed to give maximal flexibility and functional adaptability to accommodate the variety of equipment which will be moved over from the present crowded areas and which will be later installed for future projects. A conference room and general purpose rooms adjoining the elevator tower can be later expanded into a complete eighth floor, according to design plans.

The building, with a total area of 51,533 square feet, will be set back about 10 feet from the sidewalk on Mill Street and will be connected at the first four floor levels by passageways to the present medical sciences building. Exterior styling is traditional and closely the same as other buildings with which it is connected. According to Dr. R. P. Walton, Chairman of the Building Committee, completion date is set for late 1962.

Currently there are 95 active projects totalling $1,080,365 from 27 granting agencies. A number of research projects, now in the negotiation stage, are dependent on the availability of working space.

Paul B. Smith of Spartanburg has been elected president of the Student American Medical Association. Paul, a Wofford College graduate, is attending the Medical College of South Carolina.

RADIO COMMUNICATIONS NETWORK BEING DEVELOPED AT HOSPITAL

A radio network between the Chesterfield County Memorial Hospital and its doctors is being established, Hospital Administrator D. W. McCreight said recently.

A high frequency radio and a 70-foot tower has been installed at the hospital and several local doctors already have radio sets in their cars for quick communication with the hospital.

According to Mr. McCreight, the local hospital may be the only one in the state equipped with radio communications which he described as an "invaluable asset in case of emergency."

The radio transmitter has a 30-mile radius of contact, and Mr. McCreight said that Doctors Perry and Dr. Wiley of Chesterfield have also installed radio equipment.

The network is not yet completed, according to Mr. McCreight, but he predicted that soon all local and most county doctors will have radios in their cars and offices.

"Doctors may radio nurses to check on a patient's condition and nurses will have direct communication with doctors in emergency cases," he said.

The radio equipment at the hospital is valued at around $2600, but Mr. McCreight said it was bought at a "bargain" price, much less than that amount. Cost of maintenance is contracted at $10 a month.

Doctors pay for their own sets to join the network.

Announcements

INSTITUTES FOR PHYSICIANS AND NURSES

CARE OF PREMATURE INFANTS

THE NEW YORK HOSPITAL
CORNELL MEDICAL CENTER
NEW YORK CITY
1961-62

Sponsored by
New York State Department of Health
and
U. S. Children's Bureau

Institutes for the 1961-62 fiscal year are definitely scheduled to start on the following dates:

September 18, 1961
November 6, 1961
January 8, 1962
March 19, 1962
May 16, 1962

EARLY APPLICATION for these Institutes is ESSENTIAL.

The intensive program for physicians is of two weeks' duration and that for nurses is of four weeks' duration (full time). The first two weeks for nurses is given concurrently with the one for physicians.

Tuition and Stipends

Tuition is covered through a special arrangement with the New York Hospital-Cornell Medical Center. A stipend of $125 is provided to physicians attending the Institute to help cover board and lodgings for the two weeks of the Institute. A stipend of $175 is provided for nurses attending the Institute to help cover board and lodging for four weeks of the nurse's attendance at the Institute. Travel must be covered by the participant or his sponsoring agency.

Eligibility and Selection of Candidate

Teams of physicians and nurses caring for premature infants or participating in programs for the care of premature infants are eligible for the Institute.

Method of Application

Applications by physicians should be forwarded (after approval by the health commissioner or the director of Maternal and Child Health of the state in which the candidate works) to:

Dr. Charles H. Bauer, Medical Director
Institute in the Care of Premature Infants
Department of Pediatrics
The New York Hospital
525 East 68th Street
New York 21, New York

The physician's letter of application should include:

1. Professional education and experience
2. To which category the candidate belongs
3. A statement of the exact position held

Applications by nurses should be forwarded (after approval by the health commissioner or the director of Maternal and Child Health of the state in which the candidate works) to:

Miss Patricia Cummings, Nursing Director
Institute in the Care of Premature Infants
The New York Hospital
525 East 68th Street
New York 21, New York

The nurse's letter of application should include:

1. A statement of the training and experience of the applicant
2. The specific, present position of the applicant in the hospital or health department premature care program.
3. Educational preparation
4. Name of the other team applicant

It is desirable to have the applicants of both team members forwarded to the New York Hospital at the same time. Applicants must be filed at least two months before the beginning of each Institute. Final selection of candidates is the responsibility of the New York Hospital-Cornell Medical Center.

THE TENNESSEE VALLEY MEDICAL ASSEMBLY

sponsored by
The Chattanooga and Hamilton County Medical Society, Inc.
cordially invites you to attend its
9th ANNUAL ASSEMBLY
Read House Chattanooga, Tennessee
(Intersection of the Golden Gateway)
Monday, September 25, 1961
Tuesday, September 26, 1961
(AAGP members granted eleven hours category one credit for two days' attendance.)
Joseph W. Graves, M. D., 109 Medical Arts Building, Chattanooga, Tennessee, Chairman

A DATE FOR YOUR AUGUST SCHEDULE
The Eleventh Annual
POSTGRADUATE OBSTETRIC-PEDIATRIC SEMINAR
The Colonial Inn
St. Petersburg Beach, Florida
August 17-18-19, 1961
National authorities in the fields of obstetrics and pediatrics will present an outstanding program, which will be mailed to you at a later date.
Sponsored by:
Maternal Health Committee
S. C. Medical Association
Division of Maternal and Child Health
S. C. State Board of Health
South Carolina Chapter
American Academy of General Practice

TRI-STATE MEDICAL ASSOCIATION
Annual Meeting
Cavalier Hotel
Virginia Beach, Virginia
July 27th-28th

SECOND ANNUAL SUMMER SYMPOSIUM
sponsored by
BLUE RIDGE CHAPTER OF GENERAL PRACTICE
and
VIRGINIA ACADEMY OF GENERAL PRACTICE

SYMPOSIA — Inflammation (morning session) — Mental Depression (afternoon session)

Speakers:
Richard W. Payne, M. D.
Norman J. Skversky, M. D.
John J. Calabro, M. D.
Robert Irby, M. D.
Emanuel A. Daneman, M. D.
Else Kris, M. D.

ROANOKE, VIRGINIA — Hotel Roanoke — Saturday, July 22, 1961

Deaths

DR. W. S. JUDY

Dr. William S. Judy, 69, died at his home May 18, 1961. He was a retired radiologist.

He was born at St. George, son of the late Dr. Perry M. and Josephine Shuler Judy. He was a graduate of the Medical College of South Carolina, class of 1913. He interned at Roper Hospital and served in World War I, where he studied radiology. He began practice at 21 in St. George with his father and came to Greenville in 1927, practicing until his health failed.

He was a member of Buncombe Street Methodist Church asd was chairman of the board. He was a past president of the county medical society and the alumni association of the Medical College. Dr. Judy was a fellow of the American College of Radiology.

DR. W. T. GIBSON

Dr. W. T. Gibson, 77, physician of Batesburg, died recently at the Barnwell Hospital after an illness of several weeks.

Dr. Gibson was born in Marion County, and finished grade and preparatory school at Davidson, N. C. He was graduated from the University of Maryland in 1909, and was a member of Nu Sigma Nu fraternity and president of the junior class. He interned at the University Hospital in Baltimore, Md.

Dr. Gibson came to Batesburg in 1910, driving a horse and buggy from Columbia. He served his people and his community faithfully and unselfishly for half a century, and delivered between four and five thousand babies. He organized the first football team in Batesburg-Leesville, and coached it for over three years. For many years he was the team's doctor and sat on the bench with the boys. He was a veteran of World War I, and was in command of Base Hospital 109 in Vichy, France.

He was a member of the Ridge Medical Association, the District Medical Association, and an honorary member of the state and American Medical Associations.

Reduction of Barriers to Licensure of Qualified Physicians in the States

Resolution Adopted by the American Public Health Association

WHEREAS, the basic provisions of current medical licensure laws were enacted by most states at a time when there were many substandard medical schools, and when such legislation was urgently needed to protect the public against inadequately trained physicians, and

WHEREAS, medical education has improved vastly since the adoption of such licensure laws, and high standards of medical education are now protected and maintained by carefully devised systems of accreditation, and

WHEREAS, the present acute national shortage of well trained physicians is expected to persist and cannot be overcome for at least one or two decades, and many states have insufficient numbers of physicians to meet the needs of their populations, and

WHEREAS, the medical licensure laws of some states are unduly restrictive in light of the advances in medical education, and interpose unwarranted difficulties for communities which need to attract physicians, therefore be it

Resolved, that the American Public Health Association recommend to the Council of State Governments that the Council sponsor the establishment of a commission: To study the present state of medical licensing practices; to consult with the Federation of State Medical Boards of the United States, the Council on Medical Education and Hospitals of the American Medical Association and with other interested professional and academic associations, agencies and institutions; to prepare a model medical licensing law; and to encourage its uniform adoption by the states; so as to protect the public interest and to minimize the barriers to licensure of qualified physicans in the several states.

Ophthalmology and Optometry—What Is The Issue?

Medicine shares with optometry that portion of the field of medicine which deals with refraction without the use of drugs. Optometry is not a medical service. The optometrist does not participate in the medical care of patients. Although he is not qualified to decide that a physician's services are not required, he may sometimes realize that the person who comes to him for refraction needs services only a physician can give. We believe most optometrists adhere to the concept that their function is refraction and the correction of refractive errors by glasses—a concept which is in agreement with the expressed views of the medical profession. Optometrists have earned a measure of respect from ophthalmologists in refraction.

In noncycloplegic refraction optometry has adopted a part of medicine's refractive procedures. Nevertheless, the medical profession has declared voluntary

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professional association with the optometrist unethical, that is, contrary to the interest of the patient. Why?

The medical profession has an obligation to clarify this matter in the public mind. The opinion of the medical profession will be the more respected if it is supported with a frank authoritative statement of the issue.

For some years optometry has sponsored legislation and court actions which have brought it into conflict with medicine. Legislative extension of optometry to make it, in effect, ophthalmology-without-surgery-and-drugs (or in some instances, ophthalmology-without-surgery) represents an evasion of the medical practice act which threatens the public interest. By law, optometry now exercises jurisdiction over one ancillary medical worker, the optician, in several states. Legislation has been proposed repeatedly that would threaten the ancillary worker in the physician's office by the device of defining optometry in terms that could be used to accuse supporting medical personnel of "practicing optometry."

Those who are charged with responding to these situations at the state level deserve and require full information of the experience of other states and of the implications of what confronts them.

It is important that all recognize that, although ophthalmologists in the care of their patients are most often confronted with the problem of optometry, the conflict is with medicine. It is medicine that must meet the issue. Those physicians engaged in ophthalmology have a duty to make available to the profession as a whole their knowledge born of experience. It is their privilege and duty to communicate facts to the state society and American Medical Association delegates and to utilize proper forms so that a broadly based expression may be available for the guidance of medicine's official bodies which determine policy and official position. In the American Medical Association the forum is the Section on Ophthalmology; the policy-making body is the House of Delegates.

Those whose official duty it is to inquire into these matters should make known their findings. If there is to be resolution of the apparently divergent views, it must be frankly acknowledged that disagreement exists, and its nature must be clearly and dispassionately defined. Medicine owes this to itself, to optometry, to the people. Clarification is absolutely essential.

From an Editorial by Derrick Vail
J.A.M.A., 159:927.

SEAT BELTS

The recent agreement by automobile manufacturers to provide built-in attachment points for seat belts in 1962 cars is a welcome step in auto safety, in that it will provide a strong impetus to public acceptance of seat belts. This achievement can be credited to the persuasive efforts of the U. S. Public Health Service, the American Medical Association, the National Safety Council, the American College of Surgeons, several state legislatures, and other organizations and individuals concerned with traffic safety.

Despite the appropriateness of welcoming this development, Consumers Union believes that there is a possibility that it may backfire and eventually damage the cause of seat belts and of other safety measures. In order to avoid this contingency, it behooves the proponents of seat belts to take a sober look ahead, to recognize and pass along to the public some realistic perspectives on the matter. These include:

(1) The benefits to be derived from the installation of belt attachment points are entirely dependent on the public's cooperation in buying and using seat belts.

(2) The scientifically established facts about the effect of seat belts in controlling death and injury are these: belt users are just as likely to be hurt in accidents as non-users of belts, but belt users are likely to sustain injuries of a less severe nature; in comparable accidents, belt users experience about 35% fewer serious injuries than non-users; aside from "off-the-cuff" opinions and the judgments of clinical observers, there are no conclusive data with respect to fatalities — but carefully qualified predictions based on large-scale studies *suggest* a reduction in fatalities of 25% to 50%.

(3) Even though the *individual* using a seat belt can reduce his own risk of severe injury by about 35% and might reduce his own risk of death by anywhere from 25 to 50%, the *national* highway fatality toll would reflect this much reduction *only* if *all* cars, old and new, have seat belts for *all* passengers, and the belts are used.

(4) It follows that even if all 1962 cars (but only 1962 cars) were to be equipped by their owners with belts for the anchors provided, and if 1962 cars were to be 10% of the cars on the road in 1962, the overall reduction of severe injuries could be no more than 3.5% (10% of 35%) and the overall reduction of deaths would be likely to be no more than about 2.5 to 5.0% (10% of 25%, 50%).

Clearly, then, under the most favorable conditions, we cannot expect even as much as a 5% improvement in the overall picture from the seat belt attachment points in the 1962 cars.

The public, however, has been blithely led to expect (by recent newspaper reports) that the seat belt anchors will lead to a reduction of injuries and/or deaths by as much as 50% or 60%. We therefore must consider the possibility that widespread disillusionment with seat belts may result in 1963, if the touted 50% or 60% turns out to be in the order of 3 to 5%. Public acceptance of seat belts, and of other safety measures, may thereby receive a body blow.